

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Originated from the RUC Relativity Assessment – Different Performing Specialty from Survey Screen

April 2011

Chronic Wound Dermal Substitute

In October 2009, various Acellular Dermal Allograft and Tissue Cultured Allogeneic Dermal Substitute services were identified as part of the Different Performing Specialty from Survey screen. At that time the specialty societies recommended and the RUC agreed to wait for the work of the CPT Editorial Panel's Chronic Wound Dermal Substitute Workgroup to be completed before the RUC re-considers the work values for these codes.

In February 2011, the CPT Editorial Panel deleted 24 skin substitute codes, including subheading and introductory guidelines, and established a two-tier structure with 8 new codes (15271-15278) to report the application of skin substitute grafts, which are distinguished according to the anatomic location and surface area rather than by product description. The CPT Editorial Panel revised the skin replacement surgery guidelines, including definitions for surgical preparation, autografts, and skin substitute graft and added instructional parenthetical notes to instruct users on the appropriate use of the new codes. Additionally, the CPT Editorial Panel created new add-on code, 15777, to report implantation of biologic implant (et, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk).

15271 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

The RUC reviewed the survey results from 38 general surgeons and podiatrists and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC compared the physician work of 15271 to code 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44) and agreed with the specialty societies that the surveyed code requires more physician work and more total time than 12004, 45 and 29 minutes respectively. The RUC noted that code 12004 requires significantly less pre-service time than 15271, 7 versus 20 minutes, because it is typically reported with an Evaluation and Management service. Further, the intra-service time for 12004 is slightly greater than 15271, 17 versus 15 minutes, respectively, because it includes local anesthesia and draping time. Therefore, the RUC recommends the survey 25th percentile work RVU. **The RUC recommends a work RVU of 1.50 for CPT Code 15271.**

15272 Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 34 general surgeons and podiatrists and determined that the survey 25th percentile work RVU of 0.59 appropriately accounts for the work required to perform this service. The RUC compared the physician work of 15272 to code 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List*

separately in addition to code for primary procedure) (work RVU = 0.80) and agreed with the survey respondents that the key reference code requires more physician work and intra-service time than 15272, 15 and 10 minutes respectively. The RUC noted that the recommended work RVU places this service in the proper rank order with base code 15271. Therefore, the RUC recommends the survey 25th percentile work RVU. **The RUC recommends a work RVU of 0.59 for CPT Code 15272.**

15273 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

The RUC reviewed the survey results from 35 general surgeons, plastic surgeons and burn surgeons and determined that the survey median work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC compared the physician work of 15273 to code 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU = 3.65) and agreed with the survey respondents that the key reference code requires slightly more physician work to perform. The intra-service time of 20 minutes and immediate post-service time of 20 minutes are the same for both services. For further support, the RUC compared 15273 to 16035 *Escharotomy; initial incision* (work RVU = 3.74) and determined that it also requires the same intra-service and immediate post-service time, but is slightly more intense and complex to perform, typically to avoid nerves and blood vessels. Therefore, the RUC recommends the survey median work value. **The RUC recommends a work RVU of 3.50 for CPT Code 15273.**

15274 Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 30 general surgeons, plastic surgeons and burn surgeons and determined that a work RVU of 0.80, slightly below the survey 25th percentile appropriately accounts for the work required to perform this service. The RUC determined that the survey 25th percentile work RVU of 1.00 overstated the total physician work and the appropriate work RVU should be closer to that of the recommendation for code 15272 in order to maintain rank order within this family of services. The RUC compared code 15274 in relation to 15272 and agreed with the specialty societies that 15274 requires more physician work as it includes a much larger substitute (100 sq cm) and requires meticulous application to avoid wrinkles, application of multiple layers of dressings, dermal replacement and different skin substitute materials. Code 15274 includes application of skin substitutes for a size that is 4 times larger than 15272 and it is important that the graft be secure, requiring fixation often on circumferential anatomical sites. In comparison, the graft for 15272 is more of a delivery system for growth factor. The RUC determined that the physician work required to perform 15274 is equivalent to code 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children* (work RVU = 0.80) as well as similar to 76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation* (work RVU = 0.83). **The RUC recommends a work RVU of 0.80 for CPT code 15274.**

15275 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

The RUC reviewed the survey results from 38 general surgeons and podiatrists and determined that the survey 25th percentile work RVU of 1.83 appropriately accounts for the work required to perform this service. The RUC compared the physician work of 15275 to code 15002 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children* (work RVU = 3.65) and agreed with the survey respondents that the key reference code requires significantly more work and total time, 115 minutes compared to 45 minutes. For further support, the RUC compared 15275 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) and determined that the surveyed code requires less intra-service time to perform than reference code 12015, 15 and 25 minutes, respectively. The RUC noted that code 12015 requires significantly less pre-service time than 15275, 7 versus 20 minutes, because 12015 is typically reported with an Evaluation and Management service. Further, the intra-service time for 12015 is greater than 15275 because it includes lower intensity local anesthesia and draping time. Therefore, the RUC recommends the survey 25th percentile work RVU. **The RUC recommends a work RVU of 1.83 for CPT Code 15275.**

15276 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 34 general surgeons and podiatrists and determined that although the graft may be placed in cosmetically sensitive areas (ie, face), the typical graft is for the lower extremity (foot and/or multiple digits). The RUC determined 15276 is analogous to code 15272 (recommended work RVU = 0.59) in both physician work and time and should be directly crosswalked. For further support, the RUC compared 15276 to key reference code 15003 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children* (work RVU = 0.80) and determined that 15276 requires 5 minutes less intra-service time, 10 minutes versus 15 minutes, and less physician work to perform. **The RUC recommends a work RVU of 0.59 for CPT code 15276.**

15277 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

The RUC reviewed the survey results from 35 general surgeons, plastic surgeons and burn surgeons and agreed that the survey median work RVU of 4.00 appropriately accounts for the work required to perform this service. The RUC noted that 15277 requires more time to perform than the other base codes in this family of services, 25 minutes intra-service time, and is significantly more intense and complex as the site of application requires intricate work to the face, hands, fingers, etc. Dressing and fixation is more difficult on these body parts and the grafts require sutures and staples just as a regular skin graft. The RUC compared the physician work of 15277 to code 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (work RVU = 4.58) and determined that the key reference code requires more work and time to perform than 15277, 45 and 25 minutes

respectively, and should be valued higher. For further support, the RUC compared 15277 to 16035 *Escharotomy; initial incision* (work RVU = 3.74) and determined 15277 requires more physician work and time to perform, 25 versus 20 minutes intra-service time and 110 minutes versus 70 minutes total time. Therefore, the RUC recommends the survey median work RVU. **The RUC recommends a work RVU of 4.00 for CPT Code 15277.**

15278 Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof

The RUC reviewed the survey results from 30 general surgeons, plastic surgeons and burn surgeons for code 15278 and determined the physician time, intensity and complexity is greater than add-on codes 15272, 15274 and 15276 as the surveyed code requires 14 minutes intra-service time compared to 10 minutes, and includes intricate work on the head, neck, face, hands, and fingers, which requires more care in the application and dressing and fixation on these difficult body parts. These grafts require sutures and staples just as a regular skin graft. The RUC disagreed with the specialty society recommendation of the survey 25th percentile work RVU and determined the physician work was equivalent to codes 36148 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention* (work RVU = 1.00), 64494 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level* (work RVU = 1.00), and 64495 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)* (work RVU = 1.00). The RUC also noted that 15278 is approximately 40% of the work required to perform the key reference service 15116 *Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU = 2.50 x 0.40 = 1.00). **The RUC recommends a work RVU of 1.00 for CPT code 15278.**

15777 Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 32 general surgeons, plastic surgeons and breast surgeons for code 15777 and disagreed with the specialty society recommendation of the median work RVU in comparison to codes 49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)* (work RVU = 4.88) and 57267 *Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach* (work RVU = 4.88). The RUC determined that the physician work required to perform 15777 was less intense than the two aforementioned procedures and determined that the survey 25th percentile work RVU of 3.65 with 45 minutes-intra-service time appropriately accounts for the work required to perform this service. The RUC also referenced the following similar services to support recommended work RVU and intra-service time of 45 minutes: 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof* (work RVU = 3.73 and 40 minutes intra-service time), 37222 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty* (work RVU = 3.73 and 40 minutes intra-service time) and 93462 *Left heart catheterization by transseptal puncture through intact septum or by transapical puncture* (work RVU = 3.73 and 40 minutes intra-service time). **The RUC recommends a work RVU of 3.65 for CPT code 15777.**

Practice Expense

The RUC reviewed the direct practice expense inputs recommended by the specialty and agreed with minor changes to the clinical labor, supplies, and equipment.

Work Neutrality

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

New Technology

The RUC requested that this family of services be placed on the new technology list to review volume in three years to ensure that the utilization assumptions were accurate.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Surgery Integumentary System Repair (Closure) Skin Replacement Surgery and Skin Substitutes</p> <p><i>Repair of donor site requiring skin graft or local flaps is to be added as an additional procedure.</i></p> <p><u>Skin replacement surgery includes surgical preparation and topical placement of an autograft (including tissue cultured autograft) or skin substitute graft (ie, homograft, allograft, xenograft). The graft is anchored using the provider's choice of fixation. When services are performed in the office, routine dressing supplies are not reported separately.</u></p> <p><u>The following definition should be applied to those codes that reference "100 sq cm or 1% of body area of infants and children" when determining the involvement of body size: The measurement of 100 sq cm is applicable to adults and children 10 years of age and older; and percentages of body surface area apply to infants and children younger than 10 years of age. The measurements apply to the size of the recipient area.</u></p> <p><u>Procedures involving wrist and/or ankle are reported with codes that include arm or leg in the descriptor.</u></p>				

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p><u>When a primary procedure requires a skin substitute or skin autograft for definitive skin closure (eg, orbitectomy, radical mastectomy, deep tumor removal), use 15100-15278 in conjunction with primary procedure.</u></p> <p><u>For biological implant for soft tissue reinforcement, use 15777 in conjunction with primary procedure.</u></p> <p><u>The supply of skin substitute graft(s) should be reported separately in conjunction with 15271-15278.</u></p> <p>Surgical Preparation</p> <p><u>Definitions</u></p> <p><u>Surgical preparation</u> Ccodes 15002-15005 <u>for skin replacement surgery</u> describe the <u>initial</u> services related to preparing a clean and viable wound surface for placement of an <u>autograft, flap, skin replacement, skin substitute or for</u> negative pressure wound therapy. In some cases, closure may be possible using adjacent tissue transfer (14000-14061) or complex repair (13100-13153). In all cases, appreciable nonviable tissue is removed to treat a burn, traumatic wound or a necrotizing infection. The clean wound bed may also be created by incisional release of a scar contracture resulting in a surface defect from separation of tissues. The intent is to heal the wound by primary intention, or by the use of negative pressure wound therapy. Patient conditions may require the closure or application of graft, flap, skin replacement or skin substitute to be delayed, but in all cases the intent is to include these treatments or negative pressure wound therapy to heal the wound. Do not report 15002-15005 for removal of nonviable tissue/debris in a chronic wound (eg, venous or diabetic) when the wound is left to heal by secondary intention. See active wound management codes (97597-97598) and debridement codes (11042-11047) for this service. For necrotizing soft tissue infections in specific <u>anatomic</u> locations, see 11004-11008.</p> <p><i>When a primary procedure such as orbitectomy, radical mastectomy, or deep tumor removal requires skin graft for definitive closure, see appropriate anatomical subsection for primary procedure and this section for skin graft or skin substitute.</i></p> <p><u>Select the appropriate code from 15002-15005 based upon location and size of the resultant defect. For multiple wounds, sum the surface area of all wounds from all anatomic sites that are grouped together into the same code descriptor. For example, sum the surface area of all wounds on the trunk and arms. Do not sum wounds from different groupings of anatomic sites (eg, face and arms).</u></p> <p>Use 15002 or 15004, as appropriate, for excisions and incisional releases resulting in wounds up to and including 100 sq cm of surface area. Use 15003 or 15005 for each additional 100 sq cm or part thereof. <u>For example: Surgical preparation of a 20 sq cm wound on the right hand</u></p>				

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p>and a 15 sq cm wound on the left hand would be reported with a single code, 15004. Surgical preparation of a 75 sq cm wound on the right thigh and a 75 sq cm wound on the left thigh would be reported with 15002 for the first 100 sq cm and 15003 for the second 50 sq cm. If all four wounds required surgical preparation on the same day, use modifier 59 with 15002, 15003, and 15004. Report complex repairs, adjacent tissue transfer, flaps and grafts separately. Report the application of the skin substitute codes 15100-15431 separately. Do not report 15002-15005 in conjunction with 15340-15341.</p> <p><u><i>Autografts/tissue cultured autografts</i> include the harvest and/or application of an autologous skin graft. Repair of donor site requiring skin graft or local flaps is reported separately. Removal of current graft and/or simple cleansing of the wound is included, when performed. Do not report code 97602. Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure.</u></p> <p><u>Select the appropriate code from 15040-15261 based upon type of autograft and location and size of the defect. The measurements apply to the size of the recipient area. For multiple wounds, sum the surface area of all wounds from all anatomic sites that are grouped together into the same code descriptor. For example, sum the surface area of all wounds on the trunk and arms. Do not sum wounds from different groupings of anatomic sites (eg, face and arms).</u></p> <p><u><i>Skin substitute grafts</i> include non-autologous human skin (dermal or epidermal, cellular and acellular) grafts (eg, homograft, allograft), non-human skin substitute grafts (ie, xenograft), and biological products that form a sheet scaffolding for skin growth. These codes are not to be reported for application of non-graft wound dressings (eg, gel, ointment, foam, liquid) or injected skin substitutes. Removal of current graft and/or simple cleansing of the wound is included, when performed. Do not report 97602. Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure.</u></p> <p><u>Select the appropriate code from 15271-15278 based upon location and size of the defect. For multiple wounds, sum the surface area of all wounds from all anatomic sites that are grouped together into the same code descriptor. For example, sum the surface area of all wounds on the trunk and arms. Do not sum wounds from different groupings of anatomic sites (eg, face and arms).</u></p>				
15002		Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and	000	3.65 (No Change)

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		children (For linear scar revision, see 13100-13153)		
<p>APPLICATION OF SKIN REPLACEMENTS AND SKIN SUBSTITUTES</p> <p>Codes 15100-15431 describe the application of skin replacements and skin substitutes. Select the code based upon the type of skin replacement or skin substitute. The following definition should be applied to those codes that reference “100 sq cm or 1% of body area of infants and children” when determining the involvement of body size: The measurement of 100 sq cm is applicable to adults and children age 10 and older; percentages of body surface area apply to infants and children younger than 10 years of age. When square centimeters are indicated, this refers to 1 sq cm up to the stated amount. Add-on codes begin with the next sq cm (eg, 130 sq cm would be coded using a code for the first 100 sq cm and an add-on code for the next 30 sq cm). The measurements apply to the size of the recipient area.</p> <p>These codes are not intended to be reported for simple graft application alone or application stabilized with dressings (eg, by simple gauze wrap). The skin substitute/graft is anchored using the surgeon’s choice of fixation. When services are performed in the office, the supply of the skin substitute/graft should be reported separately. Routine dressing supplies are not reported separately. Application includes simple debridement of granulation tissue or recent avulsion. Use modifier 58 for staged application procedure(s).</p> <p><i>Grafts</i></p> <p>Autografts/Tissue Cultured Autografts</p>				
15120		Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)	090	11.16 (No Change)
E +15121		<p>each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)</p> <p>(Use 15121 in conjunction with 15120)</p> <p>(For eyelids, see also 67961-67975 et seq)</p>	ZZZ	2.67 (No Change)

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
E 15150		Tissue cultured epidermal <u>skin</u> autograft, trunk, arms, legs; first 25 sq cm or less	090	9.39 (No Change)
E+15151		additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) (Do not report 15151 more than once per session) (Use 15151 in conjunction with 15150)	ZZZ	2.00 (No Change)
E +15152		each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) (Use 15152 in conjunction with 15151)	ZZZ	2.50 (No Change)
E 15155		Tissue cultured epidermal <u>skin</u> autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 25 sq cm or less	090	10.14 (No Change)
E +15156		additional 1 sq cm to 75 sq cm (List separately in addition to code for primary procedure) (Do not report 15156 more than once per session) (Use 15156 in conjunction with 15155)	ZZZ	2.75 (No Change)
E +15157		each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	ZZZ	3.00 (No Change)

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<i>Acellular Dermal Replacement</i>				
D 15170		Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	090	N/A
D +15171		each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	ZZZ	N/A
D 15175		Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	090	N/A
D +15176		each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) <u>(15170-15176 have been deleted. To report see, 15271-15278)</u>	ZZZ	N/A
15260		Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	090	11.64 (No Change)
E +15261		each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure) (Use 15261 in conjunction with 15260)	ZZZ	2.23 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(For eyelids, see also 67961- <u>67975 et seq</u>) (Repair of donor site requiring skin graft or local flaps <u>is considered</u> , to be added as additional a separate procedure)		
<u>Skin Substitute Grafts</u>				
<u>The supply of skin substitute graft(s) should be reported separately in conjunction with 15271-15278. For biologic implant for soft tissue reinforcement, use 15777 in conjunction with code for primary procedure</u>				
●15271	P1	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	000	1.50
●+15272	P2	each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure) <u>(Use 15272 in conjunction with 15271)</u> <u>(For total wound surface area greater than or equal to 100 sq cm, see 15273, 15274)</u> <u>(Do not report 15271, 15272 in conjunction with 15273, 15274)</u>	ZZZ	0.59
●15273	P3	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	000	3.50
●+15274	P4	each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure)	ZZZ	0.80

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(Use 15274 in conjunction with 15273) (For total wound surface area up to 100 sq cm, see 15271, 15272)		
●15275	P5	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	000	1.83
●+15276	P6	each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure) (Use 15276 in conjunction with 15275) (For total wound surface area greater than or equal to 100 sq cm, see 15277, 15278) (Do not report 15275, 15276 in conjunction with 15277, 15278)	ZZZ	0.59
●15277	P7	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	000	4.00
●+15278	P8	each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure) (Use 15278 in conjunction with 15277) (For total wound surface area up to 100 sq cm, see 15275, 15276)	ZZZ	1.00

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(Do not report 15271-15278 in conjunction with 97602)		
<p>Allograft/Tissue Cultured Allogeneic skin substitute</p> <p>Application of a non-autologous human skin graft (ie, homograft) from a donor to a part of the recipient's body to resurface an area damaged by burns, traumatic injury, soft tissue infection and/or tissue necrosis or surgery.</p>				
D 15300		Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	090	N/A
D +15301		<p>each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)</p> <p>(15300-15301 have been deleted. To report see 15271-15274)</p>	ZZZ	N/A
D 15320		Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	090	N/A
D +15321		<p>each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)</p> <p>(15320-15321 have been deleted. To report see 15275-15278)</p>	ZZZ	N/A
D 15330		Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	090	N/A

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
D +15331		each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) (15330, 15331 have been deleted. To report, see 15271-15274)	ZZZ	N/A
D 15335		Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	090	N/A
D +15336		each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) (15335, 15336 have been deleted. To report, see 15275-15278)	ZZZ	N/A
D 15340		Tissue cultured allogeneic skin substitute; first 25 sq cm or less	010	N/A
D +15341		each additional 25 sq cm, or part thereof (List separately in addition to code for primary procedure) (15340, 15341 have been deleted. To report, see 15271-15278)	ZZZ	N/A
D 15360		Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	090	N/A
D +15361		each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)	ZZZ	N/A

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(15360, 15361 have been deleted. To report, see 15271-15274)		
D 15365		Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	090	N/A
D +15366		each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) (15365, 15366 have been deleted. To report, see 15275-15278)	ZZZ	N/A
Xenograft				
Application of a non human skin graft or biologic wound dressing (eg, porcine tissue or pigskin) to a part of the recipient's body following debridement of the burn wound or area of traumatic injury, soft tissue infection and/or tissue necrosis, or surgery.				
D 15400		Xenograft, skin (dermal), for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children	090	N/A
D +15401		each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure) (15400, 15401 have been deleted. To report, see 15271-15274)	ZZZ	N/A
D 15420		Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children	090	N/A
D+15421		each additional 100 sq cm, or each additional 1% of body area of infants	ZZZ	N/A

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>and children, or part thereof (List separately in addition to code for primary procedure)</p> <p>(15420, 15421 have been deleted. To report see 15275-15278)</p>		
D 15430		<p>Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children</p>	090	N/A
D +15431		<p>each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)</p> <p>(15430, 15431 have been deleted. To report, see 15271-15278)</p>	ZZZ	N/A
Other Flaps and Grafts				
●+15777	P9	<p>Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)</p> <p><u>(For bilateral breast procedure, report 15777 with modifier 50)</u></p> <p><u>(For implantation of mesh or other prosthesis for open incisional or ventral hernia repair, use 49568 in conjunction with 49560-49566)</u></p> <p><u>(For insertion of mesh or other prosthesis for closure of a necrotizing soft tissue infection wound, use 49568 in conjunction with 11004-11006)</u></p> <p><u>(For topical application of skin substitute graft to a wound surface, see 15271-15278)</u></p> <p><u>(For repair of anorectal fistula with plug (eg, porcine small intestine submucosa</u></p>	ZZZ	3.65

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>[SIS]), use 46707)</p> <p>(For insertion of mesh or other prosthesis for repair of pelvic floor defect, use <u>57267</u>)</p> <p>(The supply of biologic implant should be reported separately in conjunction with <u>15777</u>)</p>		
<p>Breast Repair and/or Reconstruction</p> <p><i>(To report bilateral procedure, report modifier 50 with the procedure code)</i></p> <p><i>(For biologic implant for soft tissue reinforcement, use 15777 in conjunction with primary procedure)</i></p>				

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

CPT Code:15271 Tracking Number P1 Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.50**
Global Period: 000 RUC Recommended RVU: **1.50**

CPT Descriptor: Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female with chronic venous stasis disease presents with a 24 sq cm (4.0 x 6.0) clean, granulating, stalled, full-thickness, chronic ulceration of the medial lower leg. A recent culture is negative for bacteria. The wound has failed to respond to compression therapy and standard active wound care treatment. A skin substitute graft is applied.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and/or imaging studies if available. An updated medication history is obtained, along with a review of pertinent medical problems that may have arisen since the previous visit. Explain procedure to patient/family. Review risks and complications. Obtain consent. Verify that all required supplies and instruments are available, including appropriate graft material. Assist with patient positioning to expose and stabilize procedure site. [For multiple sites, repositioning may be necessary.] Drape, and prep site. Scrub and gown. Perform "time out."

Description of Intra-Service Work: Simple cleansing of the wound bed is performed and hemostasis achieved. The wound is measured and the appropriate sized skin substitute graft is prepared and applied to the prepared wound surface, including the wound margins, and secured in place.

Description of Post-Service Work: Sterile primary and secondary dressings are applied. Discuss aftercare treatment with patient/family, including home restrictions (ie, activity, bathing). Dictate operative report and complete medical record documentation. Discuss progress with PCP (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Seth Rubenstein, DPM; Timothy Tillo, DPM; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	podiatry, general surgery				
CPT Code:	15271				
Sample Size:	250	Resp N:	38	Response: 15.2 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	1.00	6.00	19.00
Survey RVW:		0.87	1.50	2.35	3.00
Pre-Service Evaluation Time:				20.00	
Pre-Service Positioning Time:				5.00	
Pre-Service Scrub, Dress, Wait Time:				10.00	
Intra-Service Time:		5.00	15.00	15.00	20.00
Immediate Post Service-Time:		<u>10.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:

1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	15271	Recommended Physician Work RVU: 1.50		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		13.00	13.00	0.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		6.00	6.00	0.00
Intra-Service Time:		15.00		
Immediate Post Service-Time:		<u>10.00</u>		
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15002	000	3.65	RUC Time

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
12004	000	1.44	RUC Time

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 26.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 15271	<u>Key Reference CPT Code:</u> 15002	<u>Source of Time</u> RUC Time
Median Pre-Service Time	20.00	75.00	
Median Intra-Service Time	15.00	20.00	
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	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	45.00	115.00
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	2.78	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.78
Urgency of medical decision making	2.78	2.67

Technical Skill/Physical Effort (Mean)

Technical skill required	3.11	3.11
Physical effort required	2.56	2.56

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.56	2.56
Outcome depends on the skill and judgment of physician	3.44	3.22
Estimated risk of malpractice suit with poor outcome	2.56	2.67

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.78	2.56
Intra-Service intensity/complexity	3.11	3.11
Post-Service intensity/complexity	2.78	2.78

Additional Rationale and Comments

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

Based on more than a year of work by the CPT Chronic Wound Dermal Substitute Workgroup, the CPT Editorial Panel accepted multiple changes relative to skin substitute grafts, including:

- 1) Delete 24 skin substitute codes (including subheading and introductory guidelines).
- 2) Establish a two-tier structure with 8 new codes (15271-15278) to report application of skin substitute grafts which are distinguished according to the anatomic location and surface area rather than by product description.
- 3) Revise the Skin Replacement Surgery guidelines, including definitions for surgical preparation, autografts, and skin substitute graft.
- 4) Add instructional parenthetical notes throughout this section to instruct users on the appropriate use of the new codes.
- 5) Establish a new add-on code, 15777, to report implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk).

Below is an outline of how the codes relate to each other and who the surveying specialties were for each new code.

Site	CPT	Global	Total Wound Size (sq cm)	Skin Substitute Graft Size (sq cm)	Surveying Specialties
trunk, arms, legs	15271	000	1-99	1-25	podiatry, general surgery
	15272	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15273	000	100	100	plastic surgery, general surgery, burn surgery
	15274	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits	15275	000	1-99	1-25	podiatry, general surgery
	15276	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15277	000	100	100	plastic surgery, general surgery, burn surgery
	15278	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
breast, trunk	15777	ZZZ	any	any	plastic surgery, general surgery, breast surgery

Pre-time discussion

Code 15271 utilizes pre-time package 1A (facility – straightforward patient/straightforward procedure). This procedure will typically be performed in an ASC or outpatient hospital setting. An E/M will not typically be reported; unless this is the first time a patient is seen for this episode of care.

Recommendation – 15271

The multispecialty consensus panel recommends the survey 25th percentile work RVU of 1.50 for 15271. This is based on a comparison to the key reference code which requires significantly more work and to another reference code 12004, which has less total time and less total work. We note that 12004 will typically be performed with an E/M resulting in less pre-time for 12004 compared with 15271. Further, the intra-time for 12004 is slightly greater because it includes anesthesia and draping time (per RUC database intra-service includes: "Injection of local anesthetic for anesthesia and hemostasis. Waiting for adequate anesthesia. The area is cleansed and sterile draping is applied." Given these comparisons, the survey 25th percentile is supported.

The RVW recommendations for 15271-78 and 15777 taken together with estimated frequency will result in a Medicare savings of \$1.45 million (42,943 work RVUs).

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.

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

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. 16025

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

CPT Code: 15272 Tracking Number P2 Original Specialty Recommended RVU: **0.59**
Presented Recommended RVU: **0.59**
Global Period: ZZZ RUC Recommended RVU: **0.59**

CPT Descriptor: Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 75-year-old female with chronic venous stasis disease presents with a 48 sq cm (6.0 x 8.0) clean, granulating, stalled, full-thickness, chronic ulceration of the medial lower leg. A recent culture is negative for bacteria. The wound has failed to respond to compression therapy and standard active wound care treatment. After application of the first 25 sq cm of skin substitute graft (reported separately with code 152X1), additional skin substitute graft is applied. [Note: This is an add-on code. When completing this survey, only consider the additional work related to the application of the additional 23 sq cm of skin substitute graft. The first 25 sq cm would be reported separately.]

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Additional simple cleansing of the wound and hemostasis is performed. Additional skin substitute graft material is prepared and applied to the prepared wound surface, including the wound margins, and secured in place.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Seth Rubenstein, DPM; Timothy Tillo, DPM; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	podiatry, general surgery				
CPT Code:	15272				
Sample Size:	250	Resp N:	34	Response: 13.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	0.00	2.00	10.00
Survey RVW:		0.24	0.59	0.80	1.08
Pre-Service Evaluation Time:				5.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		3.00	10.00	10.00	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
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:	15272	Recommended Physician Work RVU: 0.59		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15003	ZZZ	0.80	RUC Time

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 11 % of respondents: 32.3 %

TIME ESTIMATES (Median)

	CPT Code: 15272	Key Reference CPT Code: 15003	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	10.00	15.00	
Median Immediate Post-service Time	0.00	1.00	
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	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	2.91	2.82
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.73	2.73
--	------	------

Urgency of medical decision making	2.82	2.91
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.18	3.18
--------------------------	------	------

Physical effort required	2.55	2.64
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.45	3.45
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Outcome depends on the skill and judgment of physician	3.55	3.55
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Estimated risk of malpractice suit with poor outcome	3.09	3.09
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.10	3.10
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Intra-Service intensity/complexity	3.27	3.27
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Post-Service intensity/complexity	2.80	2.80
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Additional Rationale and Comments

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

Based on more than a year of work by the CPT Chronic Wound Dermal Substitute Workgroup, the CPT Editorial Panel accepted multiple changes relative to skin substitute grafts, including:

- 1) Delete 24 skin substitute codes (including subheading and introductory guidelines).
- 2) Establish a two-tier structure with 8 new codes (15271-15278) to report application of skin substitute grafts which are distinguished according to the anatomic location and surface area rather than by product description.
- 3) Revise the Skin Replacement Surgery guidelines, including definitions for surgical preparation, autografts, and skin substitute graft.
- 4) Add instructional parenthetical notes throughout this section to instruct users on the appropriate use of the new codes.
- 5) Establish a new add-on code, 15777, to report implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk).

Below is an outline of how the codes relate to each other and who the surveying specialties were for each new code.

Site	CPT	Global	Total Wound Size (sq cm)	Skin Substitute Graft Size (sq cm)	Surveying Specialties
trunk, arms, legs	15271	000	1-99	1-25	podiatry, general surgery
	15272	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15273	000	100	100	plastic surgery, general surgery, burn surgery
	15274	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits	15275	000	1-99	1-25	podiatry, general surgery
	15276	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15277	000	100	100	plastic surgery, general surgery, burn surgery
	15278	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
breast, trunk	15777	ZZZ	any	any	plastic surgery, general surgery, breast surgery

Recommendation – 15272

The multispecialty consensus panel recommends the survey 25th percentile work RVU of 0.59 for 15272 based on a comparison to the key reference code 15003 (RVW=0.80), which takes 5 additional minutes. Relationally, the recommendation for 15272 is 40% of the recommendation for the base code.

The RVW recommendations for 15271-78 and 15777 taken together with estimated frequency will result in a Medicare savings of \$1.45 million (42,943 work RVUs).

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. 152X1

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

CPT Code: 15273 Tracking Number P3 Original Specialty Recommended RVU: **3.50**
 Presented Recommended RVU: **3.50**
 Global Period: 000 RUC Recommended RVU: **3.50**

CPT Descriptor: Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A mechanic was admitted to the burn center with burns on all four extremities and his lower back and abdomen, after his gasoline-saturated clothing was ignited from a spark. The burns involved 40% body surface area. Surgical excision of the burn tissue from the left lower leg beginning at the ankle and extending to the popliteal area was performed (reported separately). He now undergoes application of the first 100 sq cm of skin substitute graft on his left lower leg.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Explain graft procedure to patient/family. Review risks and complications. Obtain consent. Verify that all required supplies and instruments are available, including appropriate graft material.

Description of Intra-Service Work: Under general anesthesia, hemostasis of the graft site with epinephrine soaked laparotomy pads and/or topical thrombin is accomplished. Skin substitute graft totaling 100 sq cm is prepared and applied to the prepared wound surface, including the wound margins, and secured in place

Description of Post-Service Work: The wound is covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear. Write orders for care of graft for floor nurse. Dictate operative report for graft application and complete medical record documentation. Discuss progress with PCP (verbal and written). Same day hospital services also include pain control, patient hydration, oral intake, and critical patient positioning.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS; Richard Kagan, MD, FACS; Deborah Bash, MD, FACS; Melissa Crosby, MD, FACS					
Specialty(s):	plastic surgery, general surgery, burn surgery					
CPT Code:	15273					
Sample Size:	285	Resp N:	35	Response: 12.2 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	4.00	20.00	50.00	350.00
Survey RVW:		0.80	2.00	3.50	3.90	5.00
Pre-Service Evaluation Time:				40.00		
Pre-Service Positioning Time:				10.00		
Pre-Service Scrub, Dress, Wait Time:				10.00		
Intra-Service Time:		10.00	15.00	20.00	35.00	90.00
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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	15273	Recommended Physician Work RVU: 3.50				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		40.00	40.00	0.00		
Pre-Service Positioning Time:		10.00	3.00	7.00		
Pre-Service Scrub, Dress, Wait Time:		10.00	20.00	-10.00		
Intra-Service Time:		20.00				
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15002	000	3.65	RUC Time

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
16035	000	3.74	RUC Time

CPT Descriptor Escharotomy; initial incision**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**

Compare the pre-, intra-, and post-service time (by the median) and the 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: 40.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 15273	<u>Key Reference CPT Code:</u> 15002	<u>Source of Time</u> RUC Time
Median Pre-Service Time	60.00	75.00	
Median Intra-Service Time	20.00	20.00	
Median Immediate Post-service Time	20.00	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	100.00	115.00	

Other time if appropriate		
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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	3.00	3.00
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	2.93
--	------	------

Urgency of medical decision making	3.36	3.36
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.07	3.07
--------------------------	------	------

Physical effort required	2.93	2.93
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.14	3.00
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Outcome depends on the skill and judgment of physician	3.50	3.29
--	------	------

Estimated risk of malpractice suit with poor outcome	2.92	3.08
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.86	2.71
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Intra-Service intensity/complexity	3.21	3.07
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Post-Service intensity/complexity	2.79	2.64
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Additional Rationale and Comments

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

Based on more than a year of work by the CPT Chronic Wound Dermal Substitute Workgroup, the CPT Editorial Panel accepted multiple changes relative to skin substitute grafts, including:

- 1) Delete 24 skin substitute codes (including subheading and introductory guidelines).

- 2) Establish a two-tier structure with 8 new codes (15271-15278) to report application of skin substitute grafts which are distinguished according to the anatomic location and surface area rather than by product description.
- 3) Revise the Skin Replacement Surgery guidelines, including definitions for surgical preparation, autografts, and skin substitute graft.
- 4) Add instructional parenthetical notes throughout this section to instruct users on the appropriate use of the new codes.
- 5) Establish a new add-on code, 15777, to report implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk).

Below is an outline of how the codes relate to each other and who the surveying specialties were for each new code.

Site	CPT	Global	Total Wound Size (sq cm)	Skin Substitute Graft Size (sq cm)	Surveying Specialties
trunk, arms, legs	15271	000	1-99	1-25	podiatry, general surgery
	15272	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15273	000	100	100	plastic surgery, general surgery, burn surgery
	15274	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits	15275	000	1-99	1-25	podiatry, general surgery
	15276	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15277	000	100	100	plastic surgery, general surgery, burn surgery
	15278	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
breast, trunk	15777	ZZZ	any	any	plastic surgery, general surgery, breast surgery

Pre-time discussion

Code 15273 utilizes pre-time package 4 (facility – difficult patient/straightforward procedure). The scrub, dress, wait time has been reduced to the survey median time. The positioning time has been increased to the survey median time. The additional positioning time is justified by the fact that burn patients typically encounter burns on the extremities and anterior and posterior torso. The extremities will need to be positioned to allow for circumferential work (eg, suspend the arms) and anterior and posterior torso work will likely be lateral and/or prone. Re-positioning will occur throughout the procedure and the survey median minimally accounts for this time.

Recommendation – 15273

The multispecialty consensus panel recommends the survey median work RVU of 3.50 for 15273. This is supported by similar time and RVW for the key reference code 15002 and another code familiar to burn surgeons 16035.

The RVW recommendations for 15271-78 and 15777 taken together with estimated frequency will result in a Medicare savings of \$1.45 million (42,943 work RVUs).

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)

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

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. 15002

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

CPT Code: 15274 Tracking Number P4 Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: ZZZ RUC Recommended RVU: **0.80**

CPT Descriptor: Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A mechanic was admitted to the burn center with burns on all four extremities and his lower back and abdomen, after his gasoline-saturated clothing was ignited from a spark. The burns involved 40% body surface area. Surgical excision of the burn tissue from the left lower leg beginning at the ankle and extending to the popliteal area was performed (reported separately). After application of the first 100 sq cm of skin substitute graft on his left lower leg (reported separately with code 152X3), an additional 100 sq cm of skin substitute graft is applied to the same leg.

[Note: This is an add-on code. When completing this survey, only consider the additional work related to the application of an additional 100 sq cm of skin substitute graft. The first 100 sq cm would be reported separately.]

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 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Additional hemostasis of the graft site with epinephrine soaked laparotomy pads and/or topical thrombin is accomplished. Additional skin substitute graft totaling 100 sq cm is applied to the leg and secured in plac

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS; Richard Kagan, MD, FACS; Deborah Bash, MD, FACS; Melissa Crosby, MD, FACS					
Specialty(s):	plastic surgery, general surgery, burn surgery					
CPT Code:	15274					
Sample Size:	285	Resp N:	30	Response: 10.5 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	2.00	20.00	72.00	900.00
Survey RVW:		0.30	1.00	1.60	1.93	2.50
Pre-Service Evaluation Time:				0.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		3.00	5.00	10.00	15.00	30.00
Immediate Post Service-Time:		<u>0.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00			
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00		
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00	15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00	
Sub Obs Care:	<u>0.00</u>	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:	15274	Recommended Physician Work RVU: 0.80		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		<u>0.00</u>		
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15111	ZZZ	1.85	RUC Time

CPT Descriptor Epidermal autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
<u>CPT Descriptor 1</u>		0.00		
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
<u>CPT Descriptor 2</u>		0.00		

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 70.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 15274	<u>Key Reference CPT Code:</u> 15111	<u>Source of Time RUC Time</u>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	10.00	25.00	
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	10.00	25.00	
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	2.67	2.90
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.62
--	------	------

Urgency of medical decision making	2.76	3.00
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.71	2.95
--------------------------	------	------

Physical effort required	2.57	2.81
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.76	3.19
---	------	------

Outcome depends on the skill and judgment of physician	3.05	3.43
--	------	------

Estimated risk of malpractice suit with poor outcome	2.62	2.86
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	1.90	2.43
----------------------------------	------	------

Intra-Service intensity/complexity	2.57	3.00
------------------------------------	------	------

Post-Service intensity/complexity	1.90	2.43
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Additional Rationale and Comments

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

Based on more than a year of work by the CPT Chronic Wound Dermal Substitute Workgroup, the CPT Editorial Panel accepted multiple changes relative to skin substitute grafts, including:

- 1) Delete 24 skin substitute codes (including subheading and introductory guidelines).

- 2) Establish a two-tier structure with 8 new codes (15271-15278) to report application of skin substitute grafts which are distinguished according to the anatomic location and surface area rather than by product description.
- 3) Revise the Skin Replacement Surgery guidelines, including definitions for surgical preparation, autografts, and skin substitute graft.
- 4) Add instructional parenthetical notes throughout this section to instruct users on the appropriate use of the new codes.
- 5) Establish a new add-on code, 15777, to report implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk).

Below is an outline of how the codes relate to each other and who the surveying specialties were for each new code.

Site	CPT	Global	Total Wound Size (sq cm)	Skin Substitute Graft Size (sq cm)	Surveying Specialties
trunk, arms, legs	15271	000	1-99	1-25	podiatry, general surgery
	15272	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15273	000	100	100	plastic surgery, general surgery, burn surgery
	15274	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits	15275	000	1-99	1-25	podiatry, general surgery
	15276	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15277	000	100	100	plastic surgery, general surgery, burn surgery
	15278	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
breast, trunk	15777	ZZZ	any	any	plastic surgery, general surgery, breast surgery

Recommendation – 15274

The RVW recommendations for 15271-78 and 15777 taken together with estimated frequency will result in a Medicare savings of \$1.45 million (42,943 work RVUs).

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. 152X3

FREQUENCY INFORMATION

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. 10160

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

CPT Code: 15275 Tracking Number P5 Original Specialty Recommended RVU: **1.83**
Presented Recommended RVU: **1.83**
Global Period: 000 RUC Recommended RVU: **1.83**

CPT Descriptor: Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male with Type II diabetes presents with a 12.0 sq cm (3.0 x 4.0) clean, granulating, stalled, full-thickness, chronic ulceration of the plantar aspect of the right heel. A recent culture is negative for bacteria. The wound has failed to respond to standard active wound care treatment. A skin substitute graft is applied.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review labs and/or imaging studies if available. An updated medication history is obtained, along with a review of pertinent medical problems that may have arisen since the previous visit. Explain procedure to patient/family. Review risks and complications. Obtain consent. Verify that all required supplies and instruments are available, including appropriate graft material. Assist with patient positioning to expose and stabilize procedure site. [For multiple sites, repositioning may be necessary.] Drape, and prep site. Scrub and gown. Perform "time out."

Description of Intra-Service Work: Simple cleansing of the wound bed is performed and hemostasis achieved. The wound is measured and the appropriate sized skin substitute graft is prepared and applied to the prepared wound surface, including the wound margins, and secured in place.

Description of Post-Service Work: Sterile primary and secondary dressings are applied. Discuss aftercare treatment with patient/family, including home restrictions (ie, activity, bathing). Dictate operative report and complete medical record documentation. Discuss progress with PCP (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Seth Rubenstein, DPM; Timothy Tillo, DPM; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	podiatry, general surgery				
CPT Code:	15275				
Sample Size:	250	Resp N:	38	Response: 15.2 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	2.00	8.00	24.00
Survey RVW:		0.90	1.83	2.75	4.25
Pre-Service Evaluation Time:				25.00	
Pre-Service Positioning Time:				5.00	
Pre-Service Scrub, Dress, Wait Time:				10.00	
Intra-Service Time:		5.00	15.00	15.00	30.00
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:

1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	15275	Recommended Physician Work RVU: 1.83		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		13.00	13.00	0.00
Pre-Service Positioning Time:		1.00	1.00	0.00
Pre-Service Scrub, Dress, Wait Time:		6.00	6.00	0.00
Intra-Service Time:		15.00		
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 0.0	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15002	000	3.65	RUC Time

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
12015	000	1.98	RUC Time

CPT Descriptor Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 12 % of respondents: 31.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 15275	<u>Key Reference CPT Code:</u> 15002	<u>Source of Time</u> RUC Time
Median Pre-Service Time	20.00	75.00	
Median Intra-Service Time	15.00	20.00	
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	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	45.00	115.00
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	3.09	3.08
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.27	3.17
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Urgency of medical decision making	3.09	3.00
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.55	3.42
--------------------------	------	------

Physical effort required	2.73	2.58
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.18	3.08
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Outcome depends on the skill and judgment of physician	3.64	3.58
--	------	------

Estimated risk of malpractice suit with poor outcome	3.18	3.08
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.18	3.08
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Intra-Service intensity/complexity	3.45	3.50
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Post-Service intensity/complexity	2.73	2.75
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Additional Rationale and Comments

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

Based on more than a year of work by the CPT Chronic Wound Dermal Substitute Workgroup, the CPT Editorial Panel accepted multiple changes relative to skin substitute grafts, including:

- 1) Delete 24 skin substitute codes (including subheading and introductory guidelines).
- 2) Establish a two-tier structure with 8 new codes (15271-15278) to report application of skin substitute grafts which are distinguished according to the anatomic location and surface area rather than by product description.
- 3) Revise the Skin Replacement Surgery guidelines, including definitions for surgical preparation, autografts, and skin substitute graft.
- 4) Add instructional parenthetical notes throughout this section to instruct users on the appropriate use of the new codes.
- 5) Establish a new add-on code, 15777, to report implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk).

Below is an outline of how the codes relate to each other and who the surveying specialties were for each new code.

Site	CPT	Global	Total Wound Size (sq cm)	Skin Substitute Graft Size (sq cm)	Surveying Specialties
trunk, arms, legs	15271	000	1-99	1-25	podiatry, general surgery
	15272	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15273	000	100	100	plastic surgery, general surgery, burn surgery
	15274	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits	15275	000	1-99	1-25	podiatry, general surgery
	15276	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15277	000	100	100	plastic surgery, general surgery, burn surgery
	15278	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
breast, trunk	15777	ZZZ	any	any	plastic surgery, general surgery, breast surgery

Pre-time discussion

Code 15275 utilizes pre-time package 1A (facility – straightforward patient/straightforward procedure). This procedure will typically be performed in an ASC or outpatient hospital setting. An E/M will not typically be reported, unless this is the first time a patient is seen for this episode of care.

Recommendation – 15275

The multispecialty consensus panel recommends the survey 25th percentile work RVU of 1.83 for 15275. This is based on a comparison to the key reference code which requires significantly more work and to another reference code 12015, which has less total time and slightly greater work RVU. We note that 12015 will typically be performed with an E/M resulting in less pre-time for 12045 compared with 15275. Further, the intra-time for 12015 is greater than 15275 because it includes anesthesia and draping time (per RUC database intra-service includes: "Injection of local anesthetic for anesthesia and hemostasis. Waiting for adequate anesthesia. The area is cleansed and sterile draping is applied." Given these comparisons, the survey 25th percentile is supported.

The RVW recommendations for 15271-78 and 15777 taken together with estimated frequency will result in a Medicare savings of \$1.45 million (42,943 work RVUs).

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.

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

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. 16025

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

CPT Code: 15276 Tracking Number P6 Original Specialty Recommended RVU: **0.73**
Presented Recommended RVU: **0.73**
Global Period: ZZZ RUC Recommended RVU: **0.59**

CPT Descriptor: Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male with Type II diabetes presents with clean, granulating, full-thickness, chronic, stalled, ulcerations on the plantar aspect of his right and left heels. The ulcer on his left heel is 25 sq cm (5.0 x 5.0) and the ulceration on his right heel is 20 sq cm (4.0 x 5.0). A recent culture is negative for bacteria. The wounds have failed to respond to standard active wound care treatment. After application of the first 25 sq cm of skin substitute graft to the left heel (reported separately with code 152X5), an additional 20 sq cm of skin substitute graft is applied to the right heel. [Note: This is an add-on code. When completing this survey, only consider the additional work related to the application of the additional 20 sq cm of skin substitute graft. The first 25 sq cm would be reported separately.]

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Additional simple cleansing of the wound and hemostasis is performed. Additional skin substitute graft material is prepared and applied to the prepared wound surface, including the wound margins, and secured in place.

Description of Post-Service Work: Multiple sites will require additional dressings.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Seth Rubenstein, DPM; Timothy Tillo, DPM; Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS				
Specialty(s):	podiatry, general surgery				
CPT Code:	15276				
Sample Size:	250	Resp N:	34	Response: 13.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	1.00	3.00	12.00
Survey RVW:		0.30	0.73	0.94	3.60
Pre-Service Evaluation Time:				5.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		3.00	10.00	10.00	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:

ZZZ Global Code

CPT Code:	15276	Recommended Physician Work RVU: 0.59		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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? Yes

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15003	ZZZ	0.80	RUC Time

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 8 % of respondents: 23.5 %

TIME ESTIMATES (Median)

	CPT Code: 15276	Key Reference CPT Code: 15003	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	10.00	15.00	
Median Immediate Post-service Time	0.00	1.00	
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	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	2.88	2.71
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.14
--	------	------

Urgency of medical decision making	2.75	2.71
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.25	3.14
--------------------------	------	------

Physical effort required	2.50	2.57
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.63	3.43
---	------	------

Outcome depends on the skill and judgment of physician	3.38	3.14
--	------	------

Estimated risk of malpractice suit with poor outcome	2.63	2.43
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	3.14
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Intra-Service intensity/complexity	3.38	3.14
------------------------------------	------	------

Post-Service intensity/complexity	2.75	2.86
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Additional Rationale and Comments

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

Based on more than a year of work by the CPT Chronic Wound Dermal Substitute Workgroup, the CPT Editorial Panel accepted multiple changes relative to skin substitute grafts, including:

- 1) Delete 24 skin substitute codes (including subheading and introductory guidelines).
- 2) Establish a two-tier structure with 8 new codes (15271-15278) to report application of skin substitute grafts which are distinguished according to the anatomic location and surface area rather than by product description.
- 3) Revise the Skin Replacement Surgery guidelines, including definitions for surgical preparation, autografts, and skin substitute graft.
- 4) Add instructional parenthetical notes throughout this section to instruct users on the appropriate use of the new codes.
- 5) Establish a new add-on code, 15777, to report implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk).

Below is an outline of how the codes relate to each other and who the surveying specialties were for each new code.

Site	CPT	Global	Total Wound Size (sq cm)	Skin Substitute Graft Size (sq cm)	Surveying Specialties
trunk, arms, legs	15271	000	1-99	1-25	podiatry, general surgery
	15272	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15273	000	100	100	plastic surgery, general surgery, burn surgery
	15274	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits	15275	000	1-99	1-25	podiatry, general surgery
	15276	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15277	000	100	100	plastic surgery, general surgery, burn surgery
	15278	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
breast, trunk	15777	ZZZ	any	any	plastic surgery, general surgery, breast surgery

Additional post-time for ZZZ codes

Code 15276 typically involves multiple separate wounds and will require multiple additional dressings not considered in the time allotted for the primary code. The recommendation is to crosswalk one minute from the key reference code to 15276.

Recommendation – 15276

The RVW recommendations for 15271-78 and 15777 taken together with estimated frequency will result in a Medicare savings of \$1.45 million (42,943 work RVUs).

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. 152X5

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. 10160

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

CPT Code:15277 Tracking Number P7 Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **4.00**
Global Period: 000 RUC Recommended RVU: **4.00**

CPT Descriptor: Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A mechanic was admitted to the burn center with burns on all four extremities and his lower back and abdomen, after his gasoline-saturated clothing was ignited from a spark. The burns involved 40% body surface area. Surgical excision of the burn tissue from his right hand beginning at the wrist was performed (reported separately). He now undergoes application of the first 100 sq cm of skin substitute graft on his right hand and fingers.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Explain graft procedure to patient/family. Review risks and complications. Obtain consent. Verify that all required supplies and instruments are available, including appropriate graft material.

Description of Intra-Service Work: Under general anesthesia, hemostasis of the graft site with epinephrine soaked laparotomy pads and/or topical thrombin is accomplished. Skin substitute graft totaling 100 sq cm is prepared and applied to the prepared wound surface, including the wound margins, and secured in place.

Description of Post-Service Work: The wound is covered with gauze dressings and secured with a bulky dressing to prevent mechanical shear. Write orders for care of graft for floor nurse. Dictate operative report for graft application and complete medical record documentation. Discuss progress with PCP (verbal and written). Same day hospital services also include pain control, patient hydration, oral intake, and critical patient positioning.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS; Richard Kagan, MD, FACS; Deborah Bash, MD, FACS; Melissa Crosby, MD, FACS				
Specialty(s):	plastic surgery, general surgery, burn surgery				
CPT Code:	15277				
Sample Size:	285	Resp N:	35	Response: 12.2 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	3.00	15.00	25.00
Survey RVW:		1.10	2.75	4.00	5.00
Pre-Service Evaluation Time:				45.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				10.00	
Intra-Service Time:		10.00	18.00	25.00	40.00
Immediate Post Service-Time:	<u>20.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	15277	Recommended Physician Work RVU: 4.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		10.00	20.00	-10.00
Intra-Service Time:		25.00		
Immediate Post Service-Time:	<u>20.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15004	000	4.58	RUC Time

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
16035	000	3.74	RUC Time

CPT Descriptor Escharotomy; initial incision**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 45.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 15277	<u>Key Reference CPT Code:</u> 15004	<u>Source of Time</u> RUC Time
Median Pre-Service Time	65.00	75.00	
Median Intra-Service Time	25.00	45.00	
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	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	110.00	150.00	

Other time if appropriate		
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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	3.50	3.27
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.13	2.94
--	------	------

Urgency of medical decision making	3.63	3.47
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.63	3.56
--------------------------	------	------

Physical effort required	3.13	3.13
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.38
---	------	------

Outcome depends on the skill and judgment of physician	3.69	3.56
--	------	------

Estimated risk of malpractice suit with poor outcome	3.67	3.53
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.31	3.19
----------------------------------	------	------

Intra-Service intensity/complexity	3.75	3.75
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Post-Service intensity/complexity	3.19	3.06
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Additional Rationale and Comments

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

Based on more than a year of work by the CPT Chronic Wound Dermal Substitute Workgroup, the CPT Editorial Panel accepted multiple changes relative to skin substitute grafts, including:

- 1) Delete 24 skin substitute codes (including subheading and introductory guidelines).

- 2) Establish a two-tier structure with 8 new codes (15271-15278) to report application of skin substitute grafts which are distinguished according to the anatomic location and surface area rather than by product description.
- 3) Revise the Skin Replacement Surgery guidelines, including definitions for surgical preparation, autografts, and skin substitute graft.
- 4) Add instructional parenthetical notes throughout this section to instruct users on the appropriate use of the new codes.
- 5) Establish a new add-on code, 15777, to report implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk).

Below is an outline of how the codes relate to each other and who the surveying specialties were for each new code.

Site	CPT	Global	Total Wound Size (sq cm)	Skin Substitute Graft Size (sq cm)	Surveying Specialties
trunk, arms, legs	15271	000	1-99	1-25	podiatry, general surgery
	15272	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15273	000	100	100	plastic surgery, general surgery, burn surgery
	15274	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits	15275	000	1-99	1-25	podiatry, general surgery
	15276	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15277	000	100	100	plastic surgery, general surgery, burn surgery
	15278	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
breast, trunk	15777	ZZZ	any	any	plastic surgery, general surgery, breast surgery

Pre-time discussion

Code 15277 utilizes pre-time package 4 (facility – difficult patient/straightforward procedure). The scrub, dress, wait time has been reduced to the survey median time. The positioning time has been increased to the survey median time. The additional positioning time is justified by the fact that burn patients typically encounter burns on the extremities and anterior and posterior torso. The extremities will need to be positioned to allow for circumferential work (eg, suspend the arms) and anterior and posterior torso work will likely be lateral and/or prone. Re-positioning will occur throughout the procedure and the survey median minimally accounts for this time.

Recommendation – 15277

The multispecialty consensus panel recommends the survey median work RVU of 4.00 for 15277. This is supported by similar time and RVW for the key reference code 15004 and another code familiar to burn surgeons 16035.

The RVW recommendations for 15271-78 and 15777 taken together with estimated frequency will result in a Medicare savings of \$1.45 million (42,943 work RVUs).

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)

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

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. 15004

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

CPT Code: 15278 Tracking Number P8 Original Specialty Recommended RVU: **1.29**
Presented Recommended RVU: **1.29**
Global Period: ZZZ RUC Recommended RVU: **1.00**

CPT Descriptor: Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A mechanic was admitted to the burn center with burns on all four extremities and his lower back and abdomen, after his gasoline-saturated clothing was ignited from a spark. The burns involved 40% body surface area. Surgical excision of the burn tissue from his right hand beginning at the wrist was performed (reported separately). After application of the first 100 sq cm of skin substitute graft to the right hand and fingers (reported separately with code 152X7), an additional 100 sq cm of skin substitute graft is applied to his left hand and fingers. [Note: This is an add-on code. When completing this survey, only consider the additional work related to the application of an additional 100 sq cm of skin substitute graft. The first 100 sq cm would be reported separately.]

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: Additional hemostasis of the graft site with epinephrine soaked laparotomy pads and/or topical thrombin is accomplished. Additional skin substitute graft totaling 100 sq cm is applied to the leg and secured in place.

Description of Post-Service Work: Large, multiple sites will require additional dressings.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Christopher Senkowski, MD, FACS; Charles Mabry, MD, FACS; Richard Kagan, MD, FACS; Deborah Bash, MD, FACS; Melissa Crosby, MD, FACS				
Specialty(s):	plastic surgery, general surgery, burn surgery				
CPT Code:	15278				
Sample Size:	285	Resp N:	30	Response: 10.5 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	1.00	13.00	25.00
Survey RVW:		0.50	1.29	1.78	4.00
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	10.00	14.00	20.00
Immediate Post Service-Time:		<u>5.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:	15278	Recommended Physician Work RVU: 1.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		14.00		
Immediate Post Service-Time:		<u>0.00</u>		
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15116	ZZZ	2.50	RUC Time

CPT Descriptor Epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15005	ZZZ	1.60	RUC Time

CPT Descriptor Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure)

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

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including 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:** 70.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 15278	<u>Key Reference CPT Code:</u> 15116	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	14.00	35.00	
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	14.00	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	3.05	3.24
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.57	2.76
Urgency of medical decision making	3.00	3.24

Technical Skill/Physical Effort (Mean)

Technical skill required	3.33	3.62
Physical effort required	2.90	3.14

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.05	3.48
Outcome depends on the skill and judgment of physician	3.48	3.86
Estimated risk of malpractice suit with poor outcome	2.90	3.10

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.14	2.62
Intra-Service intensity/complexity	3.29	3.70
Post-Service intensity/complexity	2.10	2.76

Additional Rationale and Comments

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

Based on more than a year of work by the CPT Chronic Wound Dermal Substitute Workgroup, the CPT Editorial Panel accepted multiple changes relative to skin substitute grafts, including:

- 1) Delete 24 skin substitute codes (including subheading and introductory guidelines).
- 2) Establish a two-tier structure with 8 new codes (15271-15278) to report application of skin substitute grafts which are distinguished according to the anatomic location and surface area rather than by product description.
- 3) Revise the Skin Replacement Surgery guidelines, including definitions for surgical preparation, autografts, and skin substitute graft.
- 4) Add instructional parenthetical notes throughout this section to instruct users on the appropriate use of the new codes.
- 5) Establish a new add-on code, 15777, to report implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk).

Below is an outline of how the codes relate to each other and who the surveying specialties were for each new code.

Site	CPT	Global	Total Wound Size (sq cm)	Skin Substitute Graft Size (sq cm)	Surveying Specialties
trunk, arms, legs	15271	000	1-99	1-25	podiatry, general surgery
	15272	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15273	000	100	100	plastic surgery, general surgery, burn surgery
	15274	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits	15275	000	1-99	1-25	podiatry, general surgery
	15276	ZZZ	1-99	26-99, ea add'l 25	podiatry, general surgery
	15277	000	100	100	plastic surgery, general surgery, burn surgery
	15278	ZZZ	101-infinity	101-infinity, ea add'l 100	plastic surgery, general surgery, burn surgery
breast, trunk	15777	ZZZ	any	any	plastic surgery, general surgery, breast surgery

Recommendation – 15278

The RVW recommendations for 15271-78 and 15777 taken together with estimated frequency will result in a Medicare savings of \$1.45 million (42,943 work RVUs).

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. 152X7

FREQUENCY INFORMATION

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

15176 Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

15321 Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

15336 Acellular dermal allograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

15341 Tissue cultured allogeneic skin substitute; each additional 25 sq cm, or part thereof (List separately in addition to code for primary procedure)

15366 Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

15421 Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

15431 Acellular xenograft implant; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

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 plastic surgery How often? Sometimes

Specialty general surgery How often? Sometimes

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 is not available

Specialty	Frequency	Percentage	%
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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? 2,455

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Specialty distribution should match current distribution for codes to be deleted.

Please refer to cross-walk distribution table for calculation of estimated frequency.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

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

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

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. 10160

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

CPT Code: 15777 Tracking Number P9 Original Specialty Recommended RVU: **4.78**
 Presented Recommended RVU: **4.78**
 Global Period: ZZZ RUC Recommended RVU: **3.65**

CPT Descriptor: Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female proceeds with immediate unilateral breast reconstruction with a separately reported tissue expander following a mastectomy and sentinel lymph node dissection. A 140 sq cm piece of acellular dermal matrix is sutured to the subpectoral pocket rim before the skin flaps are brought together. The skin is closed primarily. [Note: This is an add-on code. When completing this survey, please only consider the additional physician work for implantation of the acellular dermal matrix. All other procedure(s) would be reported separately.]

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review with patient the risks/benefits associated with biologic tissue implants typically from a human cadaver source and obtain informed consent.

Description of Intra-Service Work: Following a separately reported mastectomy and sentinel node dissection, the plastic surgeon elevates the pectoralis muscle as part of a separately reported insertion of a tissue expander. Prior to the expander placement, the plastic surgeon confirms that a biologic tissue substitute is required, identifies the correct substitute, and prepares it on the sterile field according to package directions. At the lateral border of the elevated pectoralis a 140 sq cm piece of acellular dermal matrix is trimmed to shape the curve of the breast and sutured to the entire inferior and lateral border of the pectoralis major muscle. A separately reported tissue expander is then placed, and the remaining edges of the acellular dermal matrix are sutured to the chest wall. The pocket is irrigated with saline and antibiotic solution.

Description of Post-Service Work: NA

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Melissa Crosby, MD, FACS, Deborah Bash, MD, FACS, Mark Villa, MD, Charles Mabry, MD, FACS Christopher Senkowski, MD, FACS				
Specialty(s):	Plastic Surgery, General Surgery, Breast Surgery				
CPT Code:	15777				
Sample Size:	231	Resp N:	32	Response: 13.8 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	5.00	14.00	26.00
Survey RVW:		1.85	3.65	4.78	7.00
Pre-Service Evaluation Time:				5.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		15.00	30.00	45.00	60.00
Immediate Post Service-Time:		3.00			
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
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:	15777	Recommended Physician Work RVU: 3.65		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		45.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49568	ZZZ	4.88	RUC Time

CPT Descriptor Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22525	ZZZ	4.47	RUC Time	13,121

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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
63295	ZZZ	5.25	RUC Time	45

CPT Descriptor 2 Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
57267	ZZZ	4.88	RUC Time

CPT Descriptor Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (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: 23 % of respondents: 71.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 15777	<u>Key Reference CPT Code:</u> 49568	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	45.00	52.00	
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	50.00	52.00
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	3.14
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.59	2.86
--	------	------

Urgency of medical decision making	2.68	2.71
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.41	3.24
--------------------------	------	------

Physical effort required	2.91	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.57
---	------	------

Outcome depends on the skill and judgment of physician	3.77	3.48
--	------	------

Estimated risk of malpractice suit with poor outcome	3.33	3.15
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.82	2.95
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Intra-Service intensity/complexity	3.27	3.24
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Post-Service intensity/complexity	2.64	2.62
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Additional Rationale and Comments

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

Our consensus panel recommends the survey median RVW and pre/intra/post times of 5/45/0 based on strong comparison to the key reference service and the “other” reference service that has been cited, both of which have similar times, RVW, and IWP/UT. Both reference codes are also clinically very similar procedures performed by other surgical specialties.

We have recommended five minutes of additional pre-service time to account for the necessary discussion regarding the associated risks and benefits of inserting a biologic implant with a human cadaver source that will remain in the patient’s body. This discussion is not necessary for breast reconstruction procedures that will not include this biologic implant. In support of this recommendation, we present the pre-service descriptions for three recently reviewed add-on codes for which the RUC agreed to additional pre-service time:

CPT 19297 – ZZZ - Placement of radiotherapy after loading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (*List separately in addition to code for primary procedure*) RUC 2004

Pre-service time justification (5 minutes) - Additional pre-operative discussion with the patient includes the risks and benefits of placing radiotherapy after loading balloon catheter for irradiation of the breast, and obtaining consent. Prior to the procedure, the surgeon also confirms that the radiotherapy after loading balloon catheter is available in the operating room and that the size and configuration of the balloon catheter are correct.

CPT 22552 – ZZZ - Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (*List separately in addition to code for separate procedure*) RUC 2010

Pre-service time justification (5 minutes) - Additional physician work is required for the patient that will undergo multiple levels of anterior cervical discectomy fusion. The risks and possible complications are greater and need to be discussed and included/added to the consent form. Additional review and consideration of type of graft and need for plate is also necessary.

CPT 63295 – ZZZ - Osteoplastic reconstruction of dorsal spinal elements, following primary intraspinal procedure (*List separately in addition to code for primary procedure*) RUC 2004

Pre-service time justification (10 minutes) - Additional preservice time is required for patient (family) education and informed consent regarding the permanent placement of hardware (eg, miniplates).

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. This is an add-on code that is meant to be reported for soft tissue reinforcement in addition to a variety of procedures including breast operations (eg, reconstruction after mastectomy) and trunk operations (eg, removal of infected mesh).

FREQUENCY INFORMATION

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	X	Z	AI	
3	AMA/Specialty Society RVS Update Committee Recommendation																							
4	ISSUE: Chronic Wound Dermal Substitute																							
6	Source	CPT	DESC	glob	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	FAC			OFF
MIN						25th	MED	75th	MAX	EVAL		POSIT	SDW	MIN	25th	MED	75th	MAX	32		38	12		
8	current	15170	Acellular dermal replacement, tru	090	0.01			5.99			220	20	20	10			30			20	3			
9	current	15171	Acellular dermal replacement, tru	ZZZ	0.10			1.55			15	0					15			0				
10	current	15175	Acellular dermal replacement, fac	090	0.08			7.99			218	18	20	10			30			20	3			
11	current	15176	Acellular dermal replacement, fac	ZZZ	0.09			2.45			28	0					28			0				
12	current	15300	Allograft skin for temporary wound	090	0.03			4.65			166	15	18	15			20			18	2			
13	current	15301	Allograft skin for temporary wound	ZZZ	0.07			1.00			15	0					15			0				
14	current	15320	Allograft skin for temporary wound	090	0.03			5.36			188	15	20	15			40			18	2			
15	current	15321	Allograft skin for temporary wound	ZZZ	0.08			1.50			20	0					20			0				
16	current	15330	Acellular dermal allograft, trunk, a	090	0.16			3.99			79	15	15	13			18			18				
17	current	15331	Acellular dermal allograft, trunk, a	ZZZ	0.08			1.00			13	0					13			0				
18	current	15335	Acellular dermal allograft, face, sc	090	0.11			4.50			85	15	15	10			30			15				
19	current	15336	Acellular dermal allograft, face, sc	ZZZ	0.06			1.43			25	0					25			0				
20	current	15340	Tissue cultured allogeneic skin su	010	0.05			3.82			119	10	5	10			28			15		0.5	2	
21	current	15341	Tissue cultured allogeneic skin su	ZZZ	0.03			0.50			15	0					15			0				
22	current	15360	Tissue cultured allogeneic derma	090	0.00			4.02			176	20	15	10			30			15		1.0	3	
23	current	15361	Tissue cultured allogeneic derma	ZZZ	0.09			1.15			13	0					13			0				
24	current	15365	Tissue cultured allogeneic derma	090	0.02			4.30			166	15	15	10			25			15		1.0	3	
25	current	15366	Tissue cultured allogeneic derma	ZZZ	0.10			1.45			15	0					15			0				
26	current	15400	Xenograft, skin (dermal), for temp	090	0.03			4.47			166	15	10	13			25			15	1		3	
27	current	15401	Xenograft, skin (dermal), for temp	ZZZ	0.05			1.00			20	0					20			0				
28	current	15420	Xenograft skin (dermal), for temp	090	0.03			4.98			178	15	15	15			30			15	1		3	
29	current	15421	Xenograft skin (dermal), for temp	ZZZ	0.08			1.50			20	0					20			0				
30	current	15430	Acellular xenograft implant; first 1	090	0.04			6.20			213	10	5	10			15			10		0.5	9	
31	current	15431	Acellular xenograft implant ; each	ZZZ	n/a			0.00			n/a													
32																								

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	X	Z	AI	
3	AMA/Specialty Society RVS Update Committee Recommendation																							
4	ISSUE: Chronic Wound Dermal Substitute																							
6	Source	CPT	DESC	glob	IWPUT	RVW					Total Time	PRE-TIME			INTRA-TIME					IMMD POST	FAC			OFF
MIN						25th	MED	75th	MAX	EVAL		POSIT	SDW	MIN	25th	MED	75th	MAX	32		38	12		
33	KEY REF	15002	Surgical preparation or creatio	26%	0.087			3.65			115	45	15	15			20			20				
34	OTH REF	12004	Simple repair T/A/L 7.6-12.5 cm		0.070			1.44			29	5	1	1			17			5				
42	SVY	15271	T / A / L 25 cm2	38	0.099	0.87	1.50	2.35	3.00	5.00	60	20	5	10	5	15	15	20	30	10				
43	REC	15271	25TH (Pkg 1A)		0.061			1.50			45	13	1	6			15			10				
44																								
45	KEY REF	15003	Surgical preparation or creatio	32%	0.052			0.80			16	0					15			1				
53	SVY	15272	T / A / L 25+ ZZZ	34	0.058	0.24	0.59	0.80	1.08	3.30	20	5			3	10	10	20	25	5				
54	REC	15272	25TH (no pre/post)		0.059			0.59			10	0					10			0				
55																								
56	KEY REF	15002	Surgical preparation or creatio	40%	0.087			3.65			115	45	15	15			20			20				
57	OTH REF	16035	Escharotomy; initial incision		0.071			3.74			80	30					30			20				
65	SVY	15273	T / A / L 100 cm2	35	0.093	0.80	2.00	3.50	3.90	5.00	100	40	10	10	10	15	20	35	90	20				
66	REC	15273	MEDIAN (Pkg 4 +positioning)		0.093			3.50			100	40	10	10			20			20				
67																								
68	KEY REF	15111	Epidermal autograft, trunk, arm	70%	0.074			1.85			25	0					25			0				
76	SVY	15274	T / A / L 100+ ZZZ	30	0.160	0.30	1.00	1.60	1.93	2.50	10	0			3	5	10	15	30	0				
77	REC	15274	25TH (no pre/post)		0.080			0.80			10	0					10			0				
78																								

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	X	Z	AI	
3	AMA/Specialty Society RVS Update Committee Recommendation																							
4	ISSUE: Chronic Wound Dermal Substitute																							
6							RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC		OFF
7	Source	CPT	DESC	glob	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	32	38	12	
79	KEY REF	15002	Surgical preparation or creatio	32%	0.087			3.65			115	45	15	15			20			20				
80	OTH REF	12015	Simple repair HEAD 7.6-12.5 cm		0.069			1.98			37	5	1	1			25			5				
88	SVY	15275	F/N/HF/G 25 cm2	38	0.118	0.90	1.83	2.75	3.55	4.25	65	25	5	10	5	15	15	19	30	10				
89	REC	15275	25TH (Pkg 1A)		0.083			1.83			45	13	1	6			15			10				
90																								
91	KEY REF	15003	Surgical preparation or creatio	24%	0.052			0.80			16	0					15			1				
99	SVY	15276	F/N/HF/G 25+ ZZZ	34	0.071	0.30	0.73	0.94	1.25	3.60	20	5			3	10	10	20	25	5				
100	REC	15276	25TH (+post +dressings)		0.059			0.59			10	0					10			0				
101																								
102	KEY REF	15004	Surgical preparation or creatio	46%	0.054			4.58			150	45	15	15			45			30				
103	OTH REF	16035	Escharotomy; initial incision		0.071			3.74			80	30					30			20				
111	SVY	15277	F/N/HF/G 100 cm2	35	0.085	1.10	2.75	4.00	4.58	5.00	115	45	15	10	10	18	25	40	90	20				
112	REC	15277	MEDIAN (Pkg 4 +positioning)		0.090			4.00			110	40	15	10			25			20				
113																								
114	KEY REF	15116	Epidermal autograft, face, scalp	70%	0.070			2.50			35	0					35			0				
115	OTH REF	15005	Surgical preparation or creatio		0.052			1.60			21	0					20			1				
123	SVY	15278	F/N/HF/G 100+ ZZZ	30	0.123	0.50	1.29	1.78	2.50	4.00	18.5	0			5	10	14	20	45	5				
124	REC	15278	25TH (+post +dressings)		0.071			1.00			14	0					14			0				
125																								

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	X	Z	AI	
3	AMA/Specialty Society RVS Update Committee Recommendation																							
4	ISSUE: Chronic Wound Dermal Substitute																							
6							RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC		OFF
7	Source	CPT	DESC	glob	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	32	38	12	
126	KEY REF	49568	Implantation of mesh or other pro	72%	0.094			4.88			52	0					52			0				
127	OTH REF	57267	Insertion of mesh or other prosthe		0.108			4.88			45	0					45			0				
132	SVY	15777	Biologic implant ZZZ	32	0.102	1.85	3.65	4.78	4.91	7.00	53	5			15	30	45	60	120	3				
133	REC	15777	MEDIAN (+pre consent)		0.079			3.65			50	5					45			0				

ISSUE: Chronic Wound Dermal Substitute
TAB: 4

CPT	Product	Short	Long	GLOB	2011 RVW	CATEGORY	RATIONALE	CODE EST % SPLIT	2009 FRQ	EST FRQ	T/A/L = trunk, arms, legs								F/N/HF/G = face, neck, hand/feet, genital									
											15271		15272		15273		15274		15275		15276		15277		15278		15777	
											25	25 ZZZ	100	100 ZZZ	25	25 ZZZ	100	100 ZZZ	25	25 ZZZ	100	100 ZZZ	25	25 ZZZ	100	100 ZZZ	IMPLANT	
% FRQ		% FRQ		% FRQ		% FRQ		% FRQ		% FRQ		% FRQ		% FRQ		% FRQ												
15430	OASIS	ANY (100)	Acellular	090	6.20	CHRONIC	NOT SPECIFIED (87% <	94%	18,488	17,379	45%	7,820	6%	1,043	1%	174		42%	7,299	5%	869	1%	174					
15430	OASIS	ANY (100)	Acellular	090	6.20	IMPLANT	MATCH 15341 FREQ	6%	18,488	1,109															100%	1,109		
15431	OASIS	ANY (+100)	Acellular	ZZZ	0.00	CHRONIC	ALL ELSE	40%	1,627	651						50%	325							50%	325			
15431	OASIS	ANY (+100)	Acellular	ZZZ	0.00	IMPLANT	ICD ABD & PS + GS	60%	1,627	976															100%	976		

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

CPT Long Descriptor:

15272 - Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

15274 - Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure)

15276 - Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (List separately in addition to code for primary procedure)

15278 - Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children or part thereof (List separately in addition to code for primary procedure)

Global Period: ZZZ **Meeting Date:** April 2011

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

For CPT 15272, 74, 76, and 78, a consensus panel consisting of physicians from each specialty compared the necessary practice expense details to a similar add-on procedure (CPT 15341) to develop the recommendations presented for clinical staff time, supplies, and equipment.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

Clinical staff will assist the surgeon 100% of the time during the procedure. No additional clinical staff time is presented.

Post-Service Clinical Labor Activities:

N/A

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

CPT Long Descriptor:

15271 - Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

15273 - Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

15275 - Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

15277 - Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

Global Period: 000

Meeting Date: April 2011

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

For CPT 15271 and CPT 15275, a consensus panel consisting of physicians from each specialty compared the necessary practice expense details to a similar procedure (CPT 11042) to develop the recommendations presented for clinical staff time, supplies, and equipment.

For CPT 15273 and CPT 15277, a consensus panel consisting of physicians from each specialty compared the necessary practice expense details to a 000 global procedure familiar to the panel members (CPT 15004) and also used CPT 15430 and 15175 (with 090 global) as additional references for considering supplies and equipment, since these procedures are very similar to the surveyed codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic & referral forms; call the facility to schedule space and equipment needed.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

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

CPT Long Descriptor:

15271 - Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

15273 - Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

15275 - Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area

15277 - Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children

Global Period: 000

Meeting Date: April 2011

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

For CPT 15271 and CPT 15275, a consensus panel consisting of physicians from each specialty compared the necessary practice expense details to a similar procedure (CPT 11042) to develop the recommendations presented for clinical staff time, supplies, and equipment.

For CPT 15273 and CPT 15277, a consensus panel consisting of physicians from each specialty compared the necessary practice expense details to a 000 global procedure familiar to the panel members (CPT 15004) and also used CPT 15430 and 15175 (with 090 global) as additional references for considering supplies and equipment, since these procedures are very similar to the surveyed codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic & referral forms, and coordinate pre-surgery services.

Intra-Service Clinical Labor Activities:

Clinical staff will greet the patient and ensure appropriate medical records are available. The procedure supplies are assembled and procedure room prepared. Clinical staff will assist the surgeon 100% of the time during the procedure. Additional staff time includes monitoring the patient after the procedure, cleaning the room (while monitoring the patient), and reviewing instructions until next visit.

Post-Service Clinical Labor Activities:

Clinical staff will follow-up with the patient by phone and order necessary prescriptions.

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

CPT Long Descriptor: Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)

Global Period: ZZZ Meeting Date: April 2011

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

A consensus panel of plastic surgeons and general surgeons agree that this procedure would not be performed in an office setting.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No clinical staff time recommended.

Intra-Service Clinical Labor Activities:

No clinical staff time recommended.

Post-Service Clinical Labor Activities:

No clinical staff time recommended.

	A	B	C	D	E	F	G	H	I
1	Chronic Wound Dermal Substitute		CPT Code	Crosswalk 11042 approved 2010		15271		15275	
2	Meeting Date: April-2011 AMA Specialty Society RVS Update Society Recommendation	CMS	Staff	Debridement, subcutaneous tissue (includes epidermis and dermis, if		Skin Sub T / A / L 25 cm2		Skin Sub F/N/HF/G 25 cm2	
3	LOCATION	Code	Type	OFF	FAC	OFF	FAC	OFF	FAC
4	GLOBAL PERIOD			000		000		000	
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MA	66	22	54	14	54	14
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MA	11	22	8	14	8	14
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MA	52	0	43	0	43	0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MA	3	0	3	0	3	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	5	5	5	5	5	5
12	Coordinate pre-surgery services	L037D	RN/LPN/MA	3	6	3	6	3	6
13	Schedule space and equipment in facility	L037D	RN/LPN/MA	0	3	0	3	0	3
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	0	5	0	0	0	0
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MA	3	3	0	0	0	0
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	L037D	RN/LPN/MA	3		3		3	
21	Obtain vital signs	L037D	RN/LPN/MA	3		3		3	
22	Provide pre-service education/obtain consent	L037D	RN/LPN/MA	3					
23	Prepare room, equipment, supplies	L037D	RN/LPN/MA	2		2		2	
25	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA	2		2		2	
26	Sedate/apply anesthesia	L037D	RN/LPN/MA						
27	Intra-service								
28	Assist physician in performing procedure	L037D	RN/LPN/MA	15		15		15	
29	Post-Service								
30	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MA	2		3		3	
31	Clean room/equipment by physician staff	L037D	RN/LPN/MA	3		3		3	
33	Clean Surgical Instrument Package	L037D	RN/LPN/MA	10		10		10	
34	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MA	3		2		2	
36	Check dressings & wound/ home care instructions	L037D	RN/LPN/MA	6					
37	Discharge day management	L037D	RN/LPN/MA						
39	End: Patient leaves office								
40	POST-SERVICE Period								
41	Start: Patient leaves office/facility								
42	Conduct phone calls/call in prescriptions	L037D		3		3		3	

	A	B	C	D	E	F	G	H	I
1	Chronic Wound Dermal Substitute		CPT Code	Crosswalk 11042 approved 2010		15271		15275	
2	Meeting Date: April-2011 AMA Specialty Society RVS Update Society Recommendation	CMS	Staff	Debridement, subcutaneous tissue (includes epidermis and dermis, if		Skin Sub T / A / L 25 cm2		Skin Sub F/N/HF/G 25 cm2	
3	LOCATION	Code	Type	OFF	FAC	OFF	FAC	OFF	FAC
53	MEDICAL SUPPLIES		Unit						
54	pack, cleaning, surgical instruments	SA043	pack	1		1		1	
55	pack, minimum multi-specialty visit	SA048	pack	1		1		1	
56	drape, sterile barrier 16 in X 29 in	SB007	item	1		1		1	
57	drape, sterile, fenestrated 16 in x 29 in	SB011	item	1		1		1	
58	drape, sterile, for Mayo stand	SB012	item	1		1		1	
59	gloves, sterile	SB024	pair	1		1		1	
60	gown, staff, impervious	SB027	item	2		2		2	
61	mask, surgical	SB033	item			2		2	
62	towel, non-sterile	SB042	item	2		2		2	
63	underpad 2ft x 3ft (Chux)	SB044	item	1		1		1	
64	syringe 50-60ml	SC056	item	1		1		1	
65	blade, surgical (Bard-Parker)	SF007	item	2		2		2	
66	bandage, Kling, non-sterile 3in	SG018	item	1		1		1	
67	dressing, 3in x 4in (Telfa, Release)	SG035	item	2					
68	dressing, 5in x 9in (Xeroform)	SG041	item			1		1	
69	gauze, self-adherent roll 0.5in to 2in (Fabco, Gauztex)	SG052	inch	72		72		72	
70	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	2		1		1	
71	tape, surgical paper 1in (Micropore)	SG079	inch	10		10		10	
72	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1		1	
73	basin, irrigation	SJ009	item	1		1		1	
74	culture swab system (Culturette)	SL033	item	1		1		1	
75	Equipment								
76	table, power	EF031		44		33	n/a	33	n/a
77	light, surgical	EF014		44		33		33	
78	mayo stand	EF015		44		33		33	
79	instrument pack, basic (\$500-\$1499)	EQ137		51		43		43	

	A	B	C	D	E	F	G	H
1	Chronic Wound Dermal Substitute		CPT Code	15273		15277		
2	Meeting Date: April-2011 AMA Specialty Society RVS Update Society Recommendation	CMS	Staff	Skin Sub T / A / L 100 cm2		Skin Sub F/N/HF/G 100 cm2		
3	LOCATION	Code	Type	OFF	FAC	OFF	FAC	
4	GLOBAL PERIOD			000		000		
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MA	59	14	64	14	
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MA	8	14	8	14	
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MA	48	0	53	0	
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MA	3	0	3	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	5	5	5	5	
12	Coordinate pre-surgery services	L037D	RN/LPN/MA	3	6	3	6	
13	Schedule space and equipment in facility	L037D	RN/LPN/MA	0	3	0	3	
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							
20	Greet patient, provide gowning, ensure appropriate medical	L037D	RN/LPN/MA	3		3		
21	Obtain vital signs	L037D	RN/LPN/MA	3		3		
22	Provide pre-service education/obtain consent	L037D	RN/LPN/MA					
23	Prepare room, equipment, supplies	L037D	RN/LPN/MA	2		2		
24	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MA	2		2		
25	Sedate/apply anesthesia	L037D	RN/LPN/MA					
26	Intra-service							
27	Assist physician in performing procedure	L037D	RN/LPN/MA	20		25		
28	Post-Service							
29	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MA	3		3		
30	Clean room/equipment by physician staff	L037D	RN/LPN/MA	3		3		
31	Clean Surgical Instrument Package	L037D	RN/LPN/MA	10		10		
32	Complete diagnostic forms, lab & X-ray requisitions	L037D	RN/LPN/MA	2		2		
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			3		3		

	A	B	C	D	E	F	G	H
1	Chronic Wound Dermal Substitute		CPT Code	15273		15277		
2	Meeting Date: April-2011 AMA Specialty Society RVS Update Society Recommendation	CMS	Staff	Skin Sub T / A / L 100 cm2		Skin Sub F/N/HF/G 100 cm2		
3	LOCATION	Code	Type	OFF	FAC	OFF	FAC	
50	MEDICAL SUPPLIES	Code	Desc					
51	pack, minimum multi-specialty visit	SA048	pack	1		1		
52	mask, surgical	SB033	item	2		2		
53	pack, cleaning, surgical instruments	SA043	pack	1		1		
54	Post-op incision care kit (suture removal)	SA054	pack	0		1		
55	tray, suturing	SA069	tray	1		1		
56	cap, surgical	SB001	item	2		2		
57	drape, sterile barrier 16 in X 29 in	SB007	item	1		1		
58	gloves, sterile	SB024	pair	2		2		
59	gown, staff, impervious	SB027	item	2		2		
60	shoe covers, surgical	SB039	pair	2		2		
61	syringe-needle 3ml 22-26g	SC064	item	3		3		
62	cautery, monopolar, electrode tip	SF016	item	0		0		
63	cautery, patient ground pad w-cord	SF021	item	0		0		
64	scalpel with blade, surgical (#10-20)	SF033	item	1		1		
65	suture, chromic, 2-0 to 5-0	SF035	item	2		2		
66	bandage, Kling, sterile 4 in	SG020	item	2		2		
67	dressing, 5in X 9in (Xeroform)	SG041	item	1		1		
68	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1		
69	tape, surgical paper 1in (Micropore)	SG079	inch	18		18		
70	cotton balls, sterile	SG082	item	5		5		
71	lidocaine 1% w-epi inj (Xylocaine w-epi)	SH046	ml	20		20		
72	sodium chloride 0.9% irrigation (500-1000ml uou)	SH069	item	1		1		
73	povidone soln (Betadine)	SJ041	ml	10		10		
74	Equipment							
75	light, surgical	EF014		38	N/A	43	N/A	
76	table, power	EF031		38		43		
77	mayo stand	EF015		38		43		
78	instrument pack, basic (\$500-\$1499)	EQ137		45		50		
79	camera, digital (6 megapixel)	ED004		10		10		

Collagenase Injection

In February 2011, the CPT Editorial Panel created two new codes to describe a new technique for treating Dupuytren's contracture by injecting an enzyme (collagenase) into the Dupuytren's cord in order for full finger extension and manipulation.

20527 Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)

The RUC reviewed the survey results from 30 hand, plastic, and orthopaedic surgeons for code 20527 and agreed with the specialty societies that the survey 25th percentile work RVU of 1.00 appropriately accounts for the physician work required to perform this service. The RUC compared this new injection to the survey's key reference code 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel* (work RVU = 0.94). The specialty society explained that multiple injections (typically 3 times) at the site are performed, and extreme care is exercised so that unintended structures (ie, nerves, tendons) are not exposed to the enzyme and destroyed. The physician ensures the enzyme is only injected into the Dupuytren's cord, as it is highly destructive. Given this increased intensity, the surveyed code should be valued slightly greater than the reference code. In addition, the RUC compared 20527 to the CPT code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75) with the understanding that the new code is much more complex, intense, and carries more risk, as the injection of a steroid into a tendon does not include the complexity of avoiding structures to the degree that injecting collagenase includes. The RUC agreed with the specialty's survey results, and recommendation in comparison to CPT codes 20526 and 20551. **The RUC recommends the survey 25th percentile work RVU of 1.00 for CPT code 20527.**

26341 Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord

The RUC reviewed the survey results from 30 hand, plastic, and orthopaedic surgeons for code 26341 and agreed with the specialty societies that the survey 25th percentile work RVU of 1.66 appropriately accounts for the physician work required to perform this service. This service is performed the day after the injection of the enzyme. The patient's hand is swollen from the injection and examined to assess for nerve or tendon injury. The hand is prepped, local or regional block anesthesia is applied and the finger is manipulated into full extension assuring disruption of the Dupuytren's cord. Multiple manipulations at 10 minute intervals with a maximum of three manipulations may be required to obtain full extension. The specialty and the RUC considered what the total work would be if the work of Evaluation and Management services were reported, one for the day of the procedure and one for the follow-up visit. The RUC concurred with the specialty that the total work of 26341 would be between two 99213 (RVW = 1.94) and one 99213 plus one 99212 (RVW=1.45). Due to the fact the patient was seen the previous day, the specialty reduced the pre-service evaluation time in Pre-time package 6 (office procedure with anesthesia) by 7 minutes (equal to the survey median time).

The RUC also compared the work of new code 26341 to that of 11421 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm* (work RVU = 1.47) and agreed that the work of this new service required more technical expertise and work effort. **The RUC recommends the survey 25th percentile work RVU of 1.66 for CPT code 26341.**

Practice Expense: The RUC carefully reviewed the direct practice expense inputs recommended by the specialty societies and approved the clinical labor, supplies and equipment associated with these services.

CPT Code (●New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Musculoskeletal System General Introduction or Removal				
20550		Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")		0.75
●20527	Q1	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture) (For manipulation of palmar fascial cord (ie, Dupuytren's cord) post enzyme injection (eg, collagenase), use 26341)	000	1.00
Hand and Fingers Incision				
E 26045		Fasciotomy, palmar (eg, Dupuytren's contracture); open, partial (For palmar fasciotomy by enzyme injection (eg, collagenase), see 20527, 26341) (For fasciectomy, see 26121-26125)	090	5.73 (No Change)
Excision				

CPT Code (●New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
26123		Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)	090	10.88 (No Change)
E +26125		each additional digit (List separately in addition to code for primary procedure) (Use 26125 in conjunction with 26123) <u>(For palmar fasciotomy by enzyme injection (eg, collagenase), see 20527, 26341)</u> (For fasciotomy, see 26040, 26045)	ZZZ	4.60 (No Change)
Repair, Revision, and/or Reconstruction				
26340		Manipulation, finger joint, under anesthesia, each joint	090	2.80 (No Change)
●26341	Q2	Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord (For enzyme injection (eg, collagenase), palmar fascial cord (eg, Dupuytren's contracture), use 20527) (Report custom orthotic fabrication/application separately)	010	1.66

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

CPT Code: 20527 Tracking Number Q1 Original Specialty Recommended RVU: **1.00**
 Presented Recommended RVU: **1.00**
 Global Period: 000 RUC Recommended RVU: **1.00**

CPT Descriptor: Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male with Dupuytren's contracture presents with a cord resulting in a fixed flexion contracture of the metacarpophalangeal or proximal interphalangeal joint. The patient undergoes enzyme (eg, collagenase) injection into the cord. [Note: Manipulation of palmar fascial cord is reported separately.]

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Explain procedure to patient/family. Review risks and complications. Obtain consent. Verify that all required instruments and supplies are available. Prepare the injection. Assist with appropriate positioning to expose and stabilize the injection site. Prep the injection site. Scrub and glove. Perform "time out."

Description of Intra-Service Work: The contracted fascial cord is injected in three separate but proximate locations with enzyme. During the course of the injection, appropriate needle placement is confirmed by assessing neural function and tendon flexion. Great care is taken to avoid injection into the adjacent neurovascular bundles and flexor tendons.

Description of Post-Service Work: A bulky hand dressing is applied. The patient is observed for potential drug reactions. Instructions, warnings, and restrictions (eg, activity) are provided to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	Daniel Nagle, MD, FACS; Anne Miller, MD; Melissa Crosby, MD, FACS; Deborah Bash, MD, FACS; William Creevy, MD					
Specialty(s):	hand surgery, plastic surgery, orthopaedic surgery					
CPT Code:	20527					
Sample Size:	267	Resp N:	30	Response: 11.2 %		
Sample Type:	Convenience Additional Sample Information: sent to random sample of hand surgeons, plastic surgeons, and orthopaedic surgeons trained and experienced per manufacturer database					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		1.00	3.00	7.00	13.00	35.00
Survey RVW:		0.80	1.00	1.23	1.50	1.50
Pre-Service Evaluation Time:				21.00		
Pre-Service Positioning Time:				2.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		2.00	5.00	5.00	10.00	10.00
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:	20527	Recommended Physician Work RVU: 1.00			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		7.00	7.00	0.00	
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:		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:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
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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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20526	000	0.94	RUC Time

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

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
20551	000	0.75	RUC Time	217,795

CPT Descriptor 1 Injection(s); single tendon origin/insertion

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31575	000	1.10	RUC Time	557,616

CPT Descriptor 2 Laryngoscopy, flexible fiberoptic; diagnostic

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 11 % of respondents: 36.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> <u>20527</u>	<u>Key Reference CPT Code:</u> <u>20526</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	8.00	6.00	
Median Intra-Service Time	5.00	5.00	
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	18.00	16.00	

Other time if appropriate		
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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	2.64	2.55
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.09	2.45
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Urgency of medical decision making	2.00	2.00
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.91	2.45
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Physical effort required	2.73	1.73
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	2.09
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Outcome depends on the skill and judgment of physician	3.82	2.36
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Estimated risk of malpractice suit with poor outcome	3.82	2.27
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.64	2.00
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Intra-Service intensity/complexity	3.55	2.82
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Post-Service intensity/complexity	2.45	1.91
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Additional Rationale and Comments

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

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

CPT Code:26341 Tracking Number Q2 Original Specialty Recommended RVU: **1.66**
Presented Recommended RVU: **1.66**
Global Period: 010 RUC Recommended RVU: **1.66**

CPT Descriptor: Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male with Dupuytren's contracture who underwent enzyme (eg, collagenase) injection into a palmar fascial cord (separately reported) the previous day presents for manipulation of the contracted finger. [Note that fabrication and application of an orthosis would be reported separately.]

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Explain procedure to patient/family. Review risks and complications. Obtain consent. Remove the dressing and examine the injection site and contracture. Prep the hand. Scrub and glove. Administer local anesthetic. Perform "time out."

Description of Intra-Service Work: The wrist is held in flexion while gentle but firm traction is placed across the contracted finger until the rupture of the fascial cord is felt and the digit fully extends. This process can be repeated two more times at 10-minute intervals if full extension is not initially achieved. Once the digit is fully extended, the tendon function is evaluated.

Description of Post-Service Work: Cutaneous disruption, if present is dressed. Instructions on care and restrictions (eg, bathing, activity) are provided to the patient. An order is written for a hand-based splint holding the involved digit in extension. One week later, the patient's hand is examined and resolution of contracture assessed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	Daniel Nagle, MD, FACS; Anne Miller, MD; Melissa Crosby, MD, FACS; Deborah Bash, MD, FACS; William Creevy, MD					
Specialty(s):	hand surgery, plastic surgery, orthopaedic surgery					
CPT Code:	26341					
Sample Size:	267	Resp N:	30	Response: 11.2 %		
Sample Type:	Convenience Additional Sample Information: sent to random sample of hand surgeons, plastic surgeons, and orthopaedic surgeons trained and experienced per manufacturer database					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		1.00	4.00	7.00	14.00	50.00
Survey RVW:		1.50	1.66	2.50	3.00	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:		5.00	10.00	10.00	15.00	30.00
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):	23.00	99211x 0.00	12x 0.00	13x 1.00	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:	26341	Recommended Physician Work RVU: 1.66		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		10.00	17.00	-7.00
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:		10.00		
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 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	16.00	99211x 0.00	12x 1.00	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:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
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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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
10061	000	2.45	Harvard Time

CPT Descriptor Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11421	000	1.47	RUC Time	39,777

CPT Descriptor 1 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11423	000	2.06	RUC Time	18,692

CPT Descriptor 2 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
26010	000	1.59	Harvard Time

CPT Descriptor Drainage of finger abscess; simple

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 7 % of respondents: 23.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 26341	<u>Key Reference CPT Code:</u> 10061	<u>Source of Time</u> RUC Time
Median Pre-Service Time	16.00	8.00	
Median Intra-Service Time	10.00	27.00	
Median Immediate Post-service Time	10.00	8.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	0.0	19.00	
Median Office Visit Time	16.0	16.00	

Prolonged Services Time	0.0	0.00
Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	52.00	78.00
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	3.14	2.33
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.43	2.33
--	------	------

Urgency of medical decision making	2.00	2.33
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.43	2.67
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Physical effort required	2.71	2.00
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.43	2.17
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Outcome depends on the skill and judgment of physician	3.71	2.67
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Estimated risk of malpractice suit with poor outcome	3.43	2.33
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.57	2.00
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Intra-Service intensity/complexity	3.43	3.33
------------------------------------	------	------

Post-Service intensity/complexity	3.14	2.50
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Additional Rationale and Comments

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

The work related to new code 263X1 can be broken into two components: the manipulation procedure to disrupt the fascial cord and the follow-up office visit. On the day of the manipulation procedure, dressings are removed from the typically swollen hand (related to the collagenase injection given the day before) and the hand is examined to assess for nerve or tendon injury. Due to the fact the patient was seen the previous day, we are reducing the pre-service evaluation time in Pre-time package 6 by 7 minutes (equal to the survey median time). After the exam and discussion with the patient regarding the procedure, anesthesia is administered, most often local infiltration in the area of the cord to be manipulated. Alternatively, some surgeons perform a nerve block at the median and/or ulnar nerve. Anesthesia will be determined on a patient-by-patient basis depending on the severity of contracture and tolerance for pain. When the anesthetic has taken effect, the hand will be positioned and the finger gently extended to disrupt the cord. If full extension is not achieved, the process can be repeated in 10-minute intervals. Cutaneous rupture may occur, more often for PIP contractures. When successful cord disruption is attained, a temporary dressing is applied, the patient is provided instructions on daily care (eg, activity, bathing) and use of a splint. An order for fabrication of an orthotic to maintain extension of finger is written. If swelling and pain are severe, orders are written for an anti-inflammatory and/or pain medication. At the follow-up visit, the patient's hand is examined and resolution of contracture assessed.

The consensus panel reviewing the survey data does not believe the median RVW and comparison to the key reference code 10061 accurately reflect the work of 263X1. For information, we note that key reference code is currently Harvard based in the RUC database, however, the RUC reviewed 10061 in 2010 as part of the 4th 5YR. The table below shows the current RUC database information and the RUC recommendation submitted to CMS.

Source	CPT	IWPUT	MED	Time	EVAL	POSIT	SDW	MED	POST	-38	-12
KEY REF-Hvd	10061	0.036	2.45	78	8			27	8	0.5	1
KEY REF-RUC 2010	10061	0.039	2.45	83	8	3	5	25	10		2

Based on the RUC survey data and an expert panel discussion with surgeons familiar with this procedure, we are recommending the survey 25th percentile work RVU of 1.66. In support of this recommendation, we considered what the total work would be if the work were compared to that associated with E/M codes, one for the day of the procedure and one for the follow-up visit. We estimate the work would be **between 2 x 99213 (RVW = 1.94) and 1x99213 plus 1x99212 (RVW=1.45)**. While we are recommending 99212 for the follow-up visit, we note that our RUC survey indicated a near equal split between the two codes 99213 and 99212 for the follow-up visit, but leaned toward 99213. Further, for the work related to the day of the procedure, we believe the administration of anesthesia and total time spent face-to-face with the patient is slightly more work than that of a 99213 given the fact the manipulation can lead to neuropraxia as well as cutaneous disruption. Based on this discussion, we believe the 25th percentile work RVU is supported as it relates to reporting E/M work. This value is also supported by the relative comparable total work and time required for another reference code familiar to hand surgeons, 26010.

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. Custom fabrication and application of an orthotic will be performed by a PT or OT and reported separately.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 26989 or 26340

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 hand surgery How often? Sometimes

Specialty plastic surgery How often? Sometimes

Specialty orthopaedic surgery How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 4500

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Since the FDA approval of collagenase in February of 2010 approximately 4500 injections have been administered through December 31, 2010. Based on insurance coordination for sold units, commercial insurance versus Medicare is evenly split (50% each).

Specialty hand surgery Frequency 2250 Percentage 50.00 %

Specialty plastic surgery Frequency 1125 Percentage 25.00 %

Specialty orthopaedic surgery Frequency 1125 Percentage 25.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,250

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on insurance coordination for sold units, commercial insurance versus Medicare is evenly split (50% each).

Specialty hand surgery Frequency 1125 Percentage 50.00 %

Specialty plastic surgery Frequency 562 Percentage 24.97 %

Specialty orthopaedic surgery Frequency 562 Percentage 25.00 %

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

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. 20526

AMA/Specialty Society RVS Update Committee Recommendation

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

CPT Long Descriptor:

Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)

Global Period: 000

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 surgeons familiar with the procedure compared the necessary practice expense details in comparison to a similar procedure (20526) to develop the recommendations presented.

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

Code 20526 was chosen as a comparison code as it is a similar injection code. Key differences are related to the difference between the injected drugs (collagenase versus steroid).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic & referral forms. Insurance approval for injection of collagenase is a time consuming undertaking by clinical staff, similar to prior approval for surgery. Clinical staff will complete pre-procedure forms to submit to insurer, discuss coordination of benefits especially with respect to the expensive drug, and coordinate ordering and shipment of the medication from a specialty pharmacy. We therefore are recommending the maximum allowed time of 5 minutes to account for the numerous phone calls and submission of forms.

Provide pre-service education/obtain consent. There is typically at least several weeks lapse of time between patient decision to proceed with the injection and approval and scheduling of the procedure. After payer approval, clinical staff will call the patient to confirm the scheduled appointments and review the protocol and confirm the patient still wants to proceed with the injection and necessary follow-up. We are recommending 3 minutes (a phone call) for this activity.

Intra-Service Clinical Labor Activities:

Clinical staff will greet the patient and ensure appropriate medical records are available. The procedure supplies are assembled and procedure room prepared. Clinical staff will assist the surgeon 100% of the time during the injection. Post-injection, clinical staff will spend 10 minutes with the patient – this time has been distributed between monitoring the patient, cleaning the room (while monitoring the patient), and reviewing instructions until next visit.

Post-Service Clinical Labor Activities:

No time has been allotted for this service period.

AMA/Specialty Society RVS Update Committee Recommendation

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

CPT Long Descriptor:

Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)

Global Period: 000

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 surgeons familiar with this procedure compared the necessary practice expense details with a similar procedure (20526) to develop the recommendations presented. We would like to note that this procedure is expected to rarely be provided in a facility setting.

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

Code 20526 was chosen as a comparison code as it is a similar injection code. Key differences are related to the difference between the injected drugs (collagenase versus steroid).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Complete pre-service diagnostic & referral forms. Insurance approval for injection of collagenase is a time consuming undertaking by clinical staff, similar to prior approval for surgery. Clinical staff will complete pre-procedure forms to submit to insurer, discuss coordination of benefits especially with respect to the expensive drug, and coordinate ordering and shipment of the medication from a specialty pharmacy. We therefore are recommending the maximum allowed time of 5 minutes to account for the numerous phone calls and submission of forms.

Schedule space and equipment in facility. When performed in a facility setting, clinical staff will need to schedule the space and arrange for necessary supplies. Because the injection procedure and manipulation procedure must be performed within 24 hours or each other, this activity is usually bundled into one phone call to schedule both procedures. We are recommending 3 minutes (a phone call) for this activity.

Provide pre-service education/obtain consent. There is typically at least several weeks lapse of time between patient decision to proceed with the injection and approval and scheduling of the procedure. After payer approval, clinical staff will call the patient to confirm the scheduled appointments and review the protocol and confirm the patient still wants to proceed with the injection and necessary follow-up. We are recommending 3 minutes (a phone call) for this activity.

Intra-Service Clinical Labor Activities:

No time is recommended for this service period.

Post-Service Clinical Labor Activities:

No time has been allotted for this service period.

AMA Specialty Society RVS Update Committee Recommendation

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

CPT Long Descriptor:

Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord

Global Period: 010

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 surgeons familiar with the procedure compared the necessary practice expense details as they related to new code 205X1.

If you have provide 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:

This procedure will always follow within 24 hours of the injection procedure (205X1). Although clinical staff may receive a phone call regarding the swelling of the hand post injection and prior to coming to the office for this procedure, this is not typical. We are recommending no pre-service time.

Intra-Service Clinical Labor Activities:

Clinical staff will greet the patient and ensure appropriate medical records are available. The procedure supplies are assembled and procedure room prepared. Clinical staff will assist the surgeon during the injection of local anesthesia. Clinical staff will assist the surgeon 100% of the time for the manipulation procedure. Post-procedure, clinical staff will clean the room (while continuing to monitoring the patient) and review instructions until next visit.

Post-Service Clinical Labor Activities:

Time consistent with 99212 follow-up visit is indicated.

AMA Specialty Society RVS Update Committee Recommendation

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

CPT Long Descriptor:

Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord

Global Period: 010

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 surgeons familiar with the procedure compared the necessary practice expense details as they related to new code 205X1.

If you have provide 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:

This procedure will rarely be performed in a facility. When it is necessary, all pre-service clinical staff work will be bundled with injection preservice work. Therefore, we are not recommending pre-service clinical staff time for this code.

Intra-Service Clinical Labor Activities:

No time has been allotted for this service period.

Post-Service Clinical Labor Activities:

Time consistent with 99212 follow-up visit is indicated.

	A	B	C	D	E	F	G
1	AMA Specialty Society RVS Update Committee Recommendation						
2				20527		26341	
3	Meeting Date: April 2011			Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)		Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord	
4	LOCATION	Code	Staff Type	OFF	FAC	OFF	FAC
5	GLOBAL PERIOD			0	0	10	10
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	28	11	50	27
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	8	11	0	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	20	0	23	0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	27	27
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5	0	0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0	0	0	0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	3	0	0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3	3	0	0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	0	0	0	0
18	End:When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters site for procedure: Services Prior to Procedure						
21	review charts	L037D	RN/LPN/MTA				
22	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		3	
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA				
27	Sedate/apply anesthesia	L037D	RN/LPN/MTA			2	
28	Intra-service						
29	Assist physician in performing procedure - 100%	L037D	RN/LPN/MTA	5		10	
30	Post-Service						
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	4		0	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
33	Check dressings & wound/ home care instructions /coordinate OV /prescriptions	L037D	RN/LPN/MTA	3		3	
35	End: Patient leaves office						
36	POST-SERVICE Period						
37	Start: Patient leaves office/facility						
38	Conduct phone calls/call in prescriptions			0	0	0	0
39	<i>Office visits:</i>						
42	99212 27 minutes		27			1	1
46	Other						
47	Total Office Visit Time	L037D	RN/LPN/MTA	0	0	27	27
49	End: with last office visit before end of global period						
50	MEDICAL SUPPLIES	Code	Unit				
51	gloves, sterile	SB024	pair	1		1	
52	drape, sterile barrier 16in x 29in	SB007	item	1		1	
53	povidone soln (Betadine)	SJ041	ml	10		20	
54	syringe 1ml	SC052	item	2			
55	needle, 18-27g	SC029	item	2		2	
56	syringe 10-12ml	SC051	item			1	
57	lidocaine 1%-2% inj (Xylocaine)	SH047	ml			10	
58	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1	
59	bandage, strip 0.75in x 3in (Bandaid)	SG021	item				
60	bandage, Kling, non-sterile 3in	SG018	item	1		1	
61	tape, surgical paper 1in (Micropore)	SG079	inch	6		6	
62	Equipment	Code					
63	table, power	EF031		20	0	50	27
64	light, surgical	EF014		20	0	50	27

	A	B	C	D	E	F	G
1	AMA Specialty Society RVS Update Committee Recommendation						
2				20527		26341	
3	Meeting Date: April 2011			Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)		Manipulation, palmar fascial cord (ie, Dupuytren's cord), post enzyme injection (eg, collagenase), single cord	
4	LOCATION	Code	Staff Type	OFF	FAC	OFF	FAC
5	GLOBAL PERIOD			0	0	10	10
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	28	11	50	27
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	8	11	0	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	20	0	23	0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0	0	27	27
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	5	5	0	0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0	0	0	0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	3	0	0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3	3	0	0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	0	0	0	0
18	End:When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters site for procedure: Services Prior to Procedure						
21	review charts	L037D	RN/LPN/MTA				
22	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		3	
24	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA				
25	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2	
26	Prepare and position patient/ monitor patient/ set up IV	L037D	RN/LPN/MTA				
27	Sedate/apply anesthesia	L037D	RN/LPN/MTA			2	
28	Intra-service						
29	Assist physician in performing procedure - 100%	L037D	RN/LPN/MTA	5		10	
30	Post-Service						
31	Monitor pt. following service/check tubes, monitors, drains	L037D	RN/LPN/MTA	4		0	
32	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3	
33	Check dressings & wound/ home care instructions /coordinate OV /prescriptions	L037D	RN/LPN/MTA	3		3	
35	End: Patient leaves office						
36	POST-SERVICE Period						
37	Start: Patient leaves office/facility						
38	Conduct phone calls/call in prescriptions			0	0	0	0
39	<i>Office visits:</i>						
42	99212 27 minutes		27			1	1
46	Other						
47	Total Office Visit Time	L037D	RN/LPN/MTA	0	0	27	27
49	End: with last office visit before end of global period						
50	MEDICAL SUPPLIES	Code	Unit				
51	gloves, sterile	SB024	pair	1		1	
52	drape, sterile barrier 16in x 29in	SB007	item	1		1	
53	povidone soln (Betadine)	SJ041	ml	10		20	
54	syringe 1ml	SC052	item	2			
55	needle, 18-27g	SC029	item	2		2	
56	syringe 10-12ml	SC051	item			1	
57	lidocaine 1%-2% inj (Xylocaine)	SH047	ml			10	
58	gauze, sterile 4in x 4in (10 pack uou)	SG056	item	1		1	
59	bandage, strip 0.75in x 3in (Bandaid)	SG021	item				
60	bandage, Kling, non-sterile 3in	SG018	item	1		1	
61	tape, surgical paper 1in (Micropore)	SG079	inch	6		6	
62	pack, minimum multi-specialty visit	SA048	item	1		2	1
63	Equipment	Code					
64	table, power	EF031		20	0	50	27
65	light, surgical	EF014		20	0	50	27

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Identified through the Codes Reported Together 75% Together or More Screen

February 2011

Lumbar Arthrodesis

In April 2010, the Relativity Assessment Workgroup identified codes 22630 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar* and 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique when performed)* through the Codes Reported Together 75% Together or More screen. The specialty societies indicated that they would submit a code change proposal to create a new code to describe the physician work when these services are performed together on the same date of service by the same physician. Additionally, a parenthetical would be created to indicate that the separate services (22630 and 22612) not be reported together. In October 2010, the CPT Editorial Panel created two new codes to describe the services when performed together.

22633 Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and level; lumbar

The RUC reviewed the survey results from 104 neurosurgeons, orthopaedic surgeons and spine surgeons for code 22633 and agreed with the specialty societies that the survey 25th percentile work RVU of 27.75 appropriately accounts for the physician work required to perform this service. To justify this value, the RUC compared the surveyed code to the current stand alone services that are being bundled. Codes 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique when performed)* (work RVU = 23.53 and intra-time = 150 minutes) and 22630 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar* (work RVU = 22.09 and intra-time = 180 minutes) and determined that the survey 25th percentile work RVU accounts for the overlap in physician work for these two services when performed together on the same date. The survey 25th percentile work RVU of 27.75 is approximately 20% lower than the current work RVU of 34.58 for codes 22612 and 22630 when reported together.

For further support, the RUC compared 22633 to services that require similar physician work and time: codes 22857 *Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar* (work RVU = 27.13 and intra-time = 180 minutes), MPC code 44204 *Laparoscopy, surgical; colectomy, partial, with anastomosis* (work RVU = 26.42 and intra-service time = 180 minutes) and MPC code 44626 *Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)* (work RVU = 27.90 and 150 minutes intra-service time). The RUC determined that the survey median intra-service time of 200 minutes appropriately captures the physician time required to perform this service compared to the current codes billed alone and the aforementioned services and should be valued similarly. **The RUC recommends the survey 25th percentile work RVU of 27.75 for CPT code 22633.**

22634 Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and level; each additional interspace and segment

The RUC reviewed the survey results of 56 neurosurgeons, orthopaedic surgeons and spine surgeons for code 22634 and determined that the survey 25th percentile work RVU of 11.38 overestimated the physician work inherent in the service as it is similar to the sum of work RVUs, 11.65, of the codes being bundled, 22614 *Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment* (work RVU = 6.43 and intra-time = 40 minutes) and 22632 *Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace* (work RVU = 5.22 and intra-time = 60 minutes). The specialty societies indicated that the work of these two services are completely separate and unlike the base codes there is not a large amount of overlap in physician work. Code 22632 includes an exposed disk space in the spinal canal, preparing end plates and placing a bone graft in the created space, whereas 22614 includes dissecting the muscle beyond the facet processes, exposing the transverse process, drilling down the bone on the outside edge of the facet in order to apply the bone graft and get the external spinal fusion in addition to the internal spinal fusion. However, the median survey intra-service time for code 22634 is 70 minutes, which is 30% less than the sum of the intra-service time for the two combined codes, 22614 and 22632, which totals 100 minutes. The specialty societies noted and concurred with the RUC's concerns regarding the disparity between the decrease in intra-service time and the work RVUs suggested by the survey respondents. Therefore, the RUC used magnitude estimation, and compared 22634 to similar add-on codes 33884 *Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension* (work RVU = 8.20 and intra-service time = 60 minutes) and 61642 *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular family* (work RVU = 8.66 and intra-service time = 60 minutes) and determined the physician work for 22634 is analogous and should be valued similarly. The RUC noted that the sum of the work RVUs for 22614 and 22632 is 11.65 and the survey time is 30% less than the combined intra-service times of 22614 and 22632, 70 versus 100 minutes, respectively. Therefore, 11.65 work RVUs reduced by 30% to account for the reduction in intra-service time, equals 8.16 work RVUs and further supports the magnitude estimation aligning this service with other similar services in the RBRVS. **The RUC recommends a work RVU of 8.16 for CPT code 22634.**

Work Neutrality

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

Practice Expense:

The Practice Expense Subcommittee made no revisions to the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
22600		Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment	090	17.40 (No Change)
E 22610		thoracic (with or without lateral transverse technique <u>when performed</u>)	090	17.28 (No Change)
E 22612		lumbar (with or without lateral transverse technique <u>when performed</u>) <u>(Do not report 22612 in conjunction with 22630 for the same interspace and segment, use 22633)</u>	090	23.53 (No Change)
22614		each additional vertebral segment (List separately in addition to code for primary procedure) <u>(Use 22614 in conjunction with 22600, 22610, 22612, 22633 or 22630 when performed at a different level. When performing a posterior or posterolateral technique for fusion/arthrodesis at an additional level, use 22614. When performing a posterior interbody fusion arthrodesis at an additional level, use 22632). When performing a combined posterior or posterolateral technique with posterior interbody arthrodesis at an additional level, use 22634)</u> (For posterior or posterolateral arthrodesis technique, see 22600-22614) <u>(For facet joint fusion, see 0219T-0222T)</u>	ZZZ	6.43 (No Change)
22630		Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar <u>(Do not report 22630 in conjunction with 22612 for the same interspace and</u>	090	22.09 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>segment, use 22633)</u>		
22632		<p>each additional interspace (List separately in addition to code for primary procedure)</p> <p><u>(Use 22632 in conjunction with 22630, 22633, or 22612 when performed at a different level. When performing a posterior interbody fusion arthrodesis at an additional level, use 22632. When performing a posterior or posterolateral technique for fusion/arthrodesis at an additional level, use 22614). When performing a combined posterior or posterolateral technique with posterior interbody arthrodesis at an additional level, use 22634)</u></p>	ZZZ	5.22 (No Change)
●22633	E1	<p>Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and level; lumbar</p> <p><u>(Do not report with 22612 or 22630 at the same level)</u></p>	090	27.75
● ⁺ 22634	E2	<p>each additional interspace and segment (List separately in addition to code for primary procedure)</p> <p><u>(Use 22634 in conjunction with 22633)</u></p>	ZZZ	8.16

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

CPT Code: 22633 Tracking Number E1 Original Specialty Recommended RVU: **27.75**
Presented Recommended RVU: **27.75**
Global Period: 090 RUC Recommended RVU: **27.75**

CPT Descriptor: Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and level; lumbar

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female presents with a degenerative spondylolisthesis of L4-5 causing mechanical low back pain. Non-operative treatments have failed to control her symptoms.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 n/a

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review pre-operative lab work-up. Write pre-operative orders for peri-operative medications. Locate, review, and place MRI and/or other spinal imaging studies on the view box or computer terminal in the operating room. Review planned incisions and procedure. Update H&P, review current medications, review the surgical procedure, post-op recovery in and out of the hospital, and expected outcome(s) with patient and family. Sign and mark operative site. Obtain informed consent. Verify that all necessary surgical instruments, supplies, and devices are available in the operative suite. Review length and type of anesthesia with anesthesiologist. Perform pre-procedural time-out confirming patient identity, surgical site, procedure, indicated intraoperative medications and antimicrobial and DVT prophylaxis, as necessary. Monitor initial patient positioning for induction of anesthesia. Monitor initial patient positioning for placement of neuro monitoring electrodes. Following the induction of anesthesia, assist with repositioning of patient - PRONE. Verify/assist with padding of the patient to prevent pressure on neurovascular structures and placement of chin straps and arm traction devices to facilitate x-rays. Scrub and gown. Supervise prepping/draping of the patient. Perform surgical time-out.

Description of Intra-Service Work: The midline skin incision is made, the subcutaneous and muscular tissues are incised and reflected and the dorsal aspects of the relevant spinal segments are exposed. The surgical segments are identified and the posterolateral elements of the spine (e.g. facet joint(s), lamina, and/or transverse process(es)) are exposed. The necessary portion of the facet joint is removed along with the lateral aspect of the lamina are removed to expose the disc space. Additional decompression (e.g. lumbar disc herniation or lumbar stenosis), if required, is reported separately. The

the sac and nerve root(s) are identified, dissected and retracted. The disc space is identified and the posterior annulus is incised, followed by removal of disc material sufficient to allow creation of a bone graft recipient bed. Following this, the intervertebral fusion graft material(s) (e.g., allograft, autograft, intervertebral cage(s) which are reported separately) are placed unilaterally or bilaterally as determined by the spinal pathology. Following placement of the intervertebral graft, the transverse process, and/or facet are decorticated and graft material (reported separately) is placed posterolaterally for a fusion. If used, spinal instrumentation is placed (reported separately) as an adjunct to fusion. The wound is irrigated and closed in layers with application of a sterile dressing.

Description of Post-Service Work: Hospital: Sterile dressings are applied. Turn patient into the supine position. When anesthesia has been reversed, transfer patient to the recovery room. Write an OP note in the patient's record. Examine patient, check wound(s) and patient progress, monitor for abnormal neurological findings. Sign OR forms, including pre- and postoperative diagnosis, operations performed. Discuss procedure outcome with family. Dictate postop report. Dictate procedure outcome and expected recovery letter for referring physician and/or insurance company. Order and review films to check alignment of cervical spine. Write orders daily, as necessary, for medications, diet, and patient activity. Examine patient daily, check wounds and patient progress. Review nursing/other provider chart notes. Chart patient progress notes. Discuss patient progress with referring physician (verbal and written). Answer patient/family questions; nursing/other provider questions (verbal and written); and insurance staff questions. When safe to discharge patient to home, write orders for follow-up visits, post-discharge labs, x-rays, home care, and physical therapy. Write prescriptions for medications needed post-discharge. Home restrictions and activity levels (ie, diet, bathing) are discussed with the patient, family members and discharging nurse. All appropriate medical records are completed, including day of discharge progress notes, discharge summary and discharge instructions, and insurance forms.

Office: Examine patient - perform periodic neurological exams. Write orders for medications. Order and review follow-up films. Monitor wounds and remove sutures/staples, when appropriate. Review physical therapy progress and revise orders as needed. Dictate patient progress notes for medical chart. Answer patient/family questions and insurance staff questions. Discuss patient progress with referring physician (verbal and written).

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011				
Presenter(s):	John Wilson, MD; William Creevy, MD; William Sullivan, MD; G. Edward Vates, MD; John Ratliff, MD; Alexander Mason, MD; Charles Mick, MD					
Specialty(s):	Neurosurgery, Orthopaedic Surgery, Spine Surgery					
CPT Code:	22633					
Sample Size:	933	Resp N:	104	Response: 11.1 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		2.00	20.00	33.00	55.00	225.00
Survey RVW:		22.00	27.75	32.00	35.25	50.00
Pre-Service Evaluation Time:				75.00		
Pre-Service Positioning Time:				20.00		
Pre-Service Scrub, Dress, Wait Time:				20.00		
Intra-Service Time:		120.00	180.00	200.00	240.00	360.00
Immediate Post Service-Time:	30.00					
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):	100.00	99231x 1.00	99232x 2.00	99233x 0.00		
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00			
Office time/visit(s):	69.00	99211x 0.00	12x 0.00	13x 3.00	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); 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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	22633	Recommended Physician Work RVU: 27.75		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		18.00	3.00	15.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		200.00		
Immediate Post Service-Time:	30.00			
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):	100.00	99231x 1.00	99232x 2.00	99233x 0.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	
Office time/visit(s):	69.00	99211x 0.00	12x 0.00	13x 3.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22612	090	23.53	RUC Time

CPT Descriptor Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44204	090	26.42	RUC Time	10,969
<u>CPT Descriptor 1</u> Laparoscopy, surgical; colectomy, partial, with anastomosis				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44626	090	27.90	RUC Time	4,321

CPT Descriptor 2 Closure of enterostomy, large or small intestine; with resection and colorectal anastomosis (eg, closure of Hartmann type procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22857	090	27.13	RUC Time

CPT Descriptor Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 34 % of respondents: 32.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 22633	<u>Key Reference CPT Code:</u> 22612	<u>Source of Time</u> RUC Time
Median Pre-Service Time	78.00	95.00	
Median Intra-Service Time	200.00	150.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	100.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	69.0	69.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	

Median Total Time	515.00	482.00
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	4.00	3.65
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.06	3.65
Urgency of medical decision making	3.00	2.91

Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	3.71
Physical effort required	4.59	3.79

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.32	3.56
Outcome depends on the skill and judgment of physician	4.59	4.12
Estimated risk of malpractice suit with poor outcome	4.24	3.79

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.79	3.50
Intra-Service intensity/complexity	4.44	3.65
Post-Service intensity/complexity	3.65	3.18

Additional Rationale and Comments

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

The RUC Five-Year Review Identification Workgroup identified codes 22612 and 22630 as typically billed together by the same physician at the same operative session 75% of the time or more and required that a bundled code for the work be developed.

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 23,038 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Code pair 22612/22630 are reported 81% together. New code 22633 is estimated at 81% of frequency for 22630.

Specialty neurosurgery	Frequency 11970	Percentage 51.95 %	
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Specialty orthopedic surgery	Frequency 10348	Percentage 44.91 %	
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Specialty	Frequency	Percentage	%
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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

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. 22612

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

CPT Code: 22634 Tracking Number E2 Original Specialty Recommended RVU: **11.38**
Presented Recommended RVU: **11.38**
Global Period: ZZZ RUC Recommended RVU: **8.16**

CPT Descriptor: Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and level; lumbar, each additional interspace and segment (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female presents with severe disc degeneration with lateral listhesis at L4-5 above a L5-S1 lytic or isthmic spondylolisthesis. She has significant low back pain that has not responded to non-operative treatment and undergoes fusion at L4-5 and L5-S1. [NOTE: Code 226E2 is an ADD-ON code. You are being asked to consider ONLY the additional physician work related to treatment of the additional interspace and segment..]

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 , In the ASC , In the office

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is;
Discharged the same day , Kept overnight (less than 24 hours) , Admitted (more than 24 hours)

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

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: The exposed spinal segments are identified and the posterolateral elements of the spine (e.g. facet joint(s), lamina, and/or transverse process(es)) are exposed. The necessary portion of the facet joint is removed along with the lateral aspect of the lamina are removed to expose the disc space. Additional decompression (e.g. lumbar disc herniation or lumbar stenosis), if required, is reported separately. The thecal sac and nerve root(s) are identified, dissected and retracted. The disc space is identified and the posterior annulus is incised, followed by removal of disc material sufficient to allow creation of a bone graft recipient bed. Following this, the intervertebral fusion graft material(s) (e.g., allograft, autograft, intervertebral cage(s) which are reported separately) are placed unilaterally or bilaterally as determined by the spinal pathology. Following placement of the intervertebral graft, the transverse process, and/or facet are decorticated and graft material (reported separately) is placed posterolaterally for a fusion. If used, spinal instrumentation is placed (reported separately) as an adjunct to fusion.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011			
Presenter(s):	John Wilson, MD; William Creevy, MD; William Sullivan, MD; G. Edward Vates, MD; John Ratliff, MD; Alexander Mason, MD; Charles Mick, MD				
Specialty(s):	Neurosurgery, Orthopaedic Surgery, Spine Surgery				
CPT Code:	22634				
Sample Size:	933	Resp N:	56	Response: 6.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		1.00	10.00	20.00	50.00
Survey RVW:		6.00	11.38	12.25	14.14
Pre-Service Evaluation Time:				5.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		20.00	60.00	70.00	90.00
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		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 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); 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:	22634	Recommended Physician Work RVU: 11.38		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22842	ZZZ	12.56	RUC Time

CPT Descriptor Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22840	ZZZ	12.52	RUC Time	27,743

CPT Descriptor 1 Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22845	ZZZ	11.95	RUC Time

CPT Descriptor Anterior instrumentation; 2 to 3 vertebral segments (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: 19 % of respondents: 33.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 22634	<u>Key Reference CPT Code:</u> 22842	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	70.00	105.00	
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	70.00	105.00
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	4.05	3.89
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	4.00
Urgency of medical decision making	3.05	2.95

Technical Skill/Physical Effort (Mean)

Technical skill required	4.53	4.26
Physical effort required	4.63	4.37

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.32	4.21
Outcome depends on the skill and judgment of physician	4.53	4.42
Estimated risk of malpractice suit with poor outcome	4.42	4.33

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	4.00	3.72
Intra-Service intensity/complexity	4.42	4.11
Post-Service intensity/complexity	3.63	3.42

Additional Rationale and Comments

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

The RUC Five-Year Review Identification Workgroup identified codes 22614 and 22632 as typically billed together by the same physician at the same operative session 75% of the time or more and required that a bundled code for the work be developed.

New code 22634 was created to bundle codes 22614 and 22632.

A new RUC survey was conducted jointly by the AANS/CNS, AAOS, and NASS, with 56 survey responses.

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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 22614, 22632

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 neurosurgery How often? Commonly

Specialty orthopaedic surgery How often? Commonly

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	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 9,118
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please

explain the rationale for this estimate. Code pair 22614/22632 are reported 83% together. New code 22634 is estimated at 83% of frequency for 22632.

Specialty neurosurgery	Frequency 4810	Percentage 52.75 %
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Specialty orthopedic surgery	Frequency 4017	Percentage 44.05 %
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Specialty	Frequency	Percentage	%
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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

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. 22614

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

CPT Long Descriptor:

E1	090	●22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar (Do not report with 22612 or 22630 at the same level)
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Global Period 090

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

A joint specialty panel representing neurosurgery, orthopaedic surgery, and spine surgery discussed the practice expense requirements for 22633 and determined that the standard 90-day global inputs would apply.

This is a facility only code.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Pre-service diagnostic & referral forms are completed. Pre-surgery clearance is arranged and verified. The operation and equipment/supplies necessary are scheduled. Talk with the patient and family about pre-, and post-operative expectations and possible complications. Explain the operation to the patient and family. Review informed consent. Contact the patient prior to surgery to verify prescribed changes in medications and pre-operative cleansing and diet. The standard 60 minutes for 90-day global procedures plus 15 minutes for coordination of care as this is a complex spine procedure have been applied.

Intra-Service Clinical Labor Activities:

Clinical staff communicates with the facility staff, patient's family, insurance staff, and PCP/referring physician regarding discharge instructions and follow-up requirements. The standard 12-minutes for inpatient discharge has been applied.

Post-Service Clinical Labor Activities:

Standard times to ready patient/records and assist physician at each post-op office visit have been applied.

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
ZZZ Day Global Periods
Facility Direct Inputs**

CPT Long Descriptor:

E2	ZZZ	●+ 22634	<p>Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar each additional level (List separately in addition to code for primary procedure)</p> <p><u>(Use 22634 in conjunction with 22633)</u></p>
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Global Period ZZZ

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

A joint specialty panel representing neurosurgery, orthopaedic surgery, and spine surgery discussed the practice expense requirements for 22634 and determined that the standard 90-day global inputs would apply.

This is a facility only code.

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	AMA/Specialty Society RVS Update Committee Recommendation			E1		E2	
2	Meeting Date: February 2011			22633		22634	
3				Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar		...each additional level (List separately in addition to code for primary procedure)	
4	LOCATION	Code	Staff Type	NF	FAC	NF	FAC
5	GLOBAL PERIOD			90	90	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	180	n/a	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	60	n/a	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	12	n/a	0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	108	n/a	0
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	0	5	0	0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0	20	0	0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	8	0	0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0	20	0	0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	0	7	0	0
17	Other Clinical Activity:coordination of care	L037D	RN/LPN/MTA	0	0	0	0
18	End:When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters site for procedure: Services Prior to Procedure						
39	Discharge day management	L037D	RN/LPN/MTA	0	12	0	0
41	End: Patient leaves office						
42	POST-SERVICE Period						
43	Start: Patient leaves office/facility						
44	Conduct phone calls/call in prescriptions						
45	<i>Office visits:</i>						
46	<i>List Number and Level of Office Visits</i>						
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36	0	3	0	0
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53	Total Office Visit Time	L037D	RN/LPN/MTA	0	108	0	0
54	Other Total:						
55	End: with last office visit before end of global period						
56	MEDICAL SUPPLIES	Code	Unit				
57	pack, minimum multi-specialty visit	SA048	pack	0	3	0	0
58	pack, post-op incision care (suture & staple)	SA053	pack	0	1	0	0
59	Equipment	Code					
60	table, power	EF031		0	108	0	0
61	light, surgical	EF014		0	108	0	0

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			E1		E2	
2	Meeting Date: February 2011			22633		22634	
3				Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar		...each additional level (List separately in addition to code for primary procedure)	
4	LOCATION	Code	Staff Type	OFF	FAC	OFF	FAC
5	GLOBAL PERIOD			90	90	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	195	n/a	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	75	n/a	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	12	n/a	0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	108	n/a	0
10	PRE-SERVICE						
11	Start: Following visit when decision for surgery or procedure made						
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	0	5	0	0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0	20	0	0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	8	0	0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0	20	0	0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	0	7	0	0
17	Other Clinical Activity:coordination of care	L037D	RN/LPN/MTA	0	15	0	0
18	End:When patient enters office/facility for surgery/procedure						
19	SERVICE PERIOD						
20	Start: When patient enters site for procedure: Services Prior to Procedure						
39	Discharge day management	L037D	RN/LPN/MTA	0	12	0	0
41	End: Patient leaves office						
42	POST-SERVICE Period						
43	Start: Patient leaves office/facility						
44	Conduct phone calls/call in prescriptions						
45	<i>Office visits:</i>						
46	<i>List Number and Level of Office Visits</i>						
47	99211 16 minutes		16				
48	99212 27 minutes		27				
49	99213 36 minutes		36	0	3	0	0
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
53	Total Office Visit Time	L037D	RN/LPN/MTA	0	108	0	0
54	Other Total:						
55	End: with last office visit before end of global period						
56	MEDICAL SUPPLIES	Code	Unit				
57	pack, minimum multi-specialty visit	SA048	pack	0	3	0	0
58	pack, post-op incision care (suture & staple)	SA053	pack	0	1	0	0
59	Equipment	Code					
60	table, power	EF031		0	108	0	0
61	light, surgical	EF014		0	108	0	0

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment – Different Performing Specialty from Survey Screen

April 2011

SI Joint Injection Revision

In October 2009, the Relativity Assessment Workgroup identified CPT code 27096 through the Different Performing Specialty from Survey Screen. The Workgroup asked the specialties to revise the action plan to consider the reporting of multiple codes on the same date of service. In April 2010, the Workgroup referred the service to the CPT Editorial Panel to change the descriptor to include “requiring fluoroscopic guidance.” In February 2011, the CPT Editorial Panel changed the descriptor for 27096 to meet the RUC’s request to bundle commonly performed services together.

27096 Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

The RUC reviewed the survey results from 55 pain medicine physicians for CPT code 27096. The RUC analyzed the survey’s median physician work value and agreed that the respondents overestimated the physician work involved in the service. The RUC arrived at this conclusion by comparing 27096 to the key reference service 64493 *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* (work RVU= 1.52 and total time= 42 minutes). The reference service has greater intra-service time compared to the surveyed code, 15 minutes compared to 11 minutes, and similar intensity and complexity. In addition, the RUC compared 27096 to CPT code 11980 *Subcutaneous hormone pellet implantation* (work RVU= 1.48) and agreed that the two services are similar in intra-service time, 11 minutes compared to 12.5 minutes, and intensity and the physician work should be directly crosswalked at 1.48 work RVUs. To further justify this work value, the RUC reviewed 65430 *Scraping of cornea, diagnostic, for smear and/or culture* (work RVU= 1.47). These services have analogous physician work and intensity, with similar intra-service time of 10 minutes and 11 minutes, respectively. The RUC recognizes that this value is a significant reduction in work RVUs from the current component billing for the bundled code, 27096 (work RVU= 1.40) and 73542 (work RVU= 0.59) or 77003 (work RVU= 0.60). **The RUC recommends a work RVU of 1.48 for CPT code 27096.**

Work Neutrality

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

Practice Expense

The RUC reviewed the direct practice expense inputs recommended by the specialty and agreed upon with minor changes to the clinical labor, and equipment. The specialty explained that the performing specialties had changed, along with the standard of care, where pain medicine physicians are more likely to perform the service with the assistance of a nurse and a C-ARM (vs. fluoroscopy room) in the non-facility setting.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲27096	R1	<p><u>Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed</u></p> <p>(27096 is to be used only with imaging confirmation of intra-articular needle positioning)</p> <p><u>(If imaging is not performed, use 20552)</u></p> <p><u>(For radiological supervision and interpretation of sacroiliac joint arthrography, use 73542)</u></p> <p><u>(For fluoroscopic guidance without formal arthrography, use 77003)</u></p> <p>(Code 27096 is a unilateral procedure. For bilateral procedure, use modifier 50)</p>	000	1.48
<p>Radiology Diagnostic Radiology (Diagnostic Imaging) Lower Extremities</p>				
D 73542		<p>Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation</p>	XXX	N/A

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>(Do not report 73542 in conjunction with 77002)</p> <p>(73542 has been deleted, for arthrography use 27096)</p> <p>(For procedure, use 27096. If formal arthrography is not performed, recorded, and formal radiologic report is not issued, use 77003 for fluoroscopic guidance for sacroiliac joint injections)</p> <p>(73542 requires formal recorded arthrography with a separate written report. If performed in conjunction with an SI injection (27096), report the injection code with modifier 52)</p>		
E 76942		<p>Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation</p> <p>(Do not report 76942 in conjunction with <u>27096</u>, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 64479-64484, 64490-64495, 76975, 0228T-0231T, 0232T, 0249T)</p>	XXX	0.67 (No Change)
Radiologic Guidance Fluroscopic Guidance				
E 77003		<p>Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or, subarachnoid, or sacroiliac joint), including neurolytic agent destruction</p> <p>(Injection of contrast during fluoroscopic guidance and localization [77003] is included in 22526, 22527, <u>27096</u>, 62263, 62264, 62267, 62270-62282, 62310-62319)</p> <p>(Fluoroscopic guidance for subarachnoid puncture for diagnostic radiographic myelography is included in supervision and interpretation codes 72240-72270)</p>	XXX	0.60 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>(For epidural or subarachnoid needle or catheter placement and injection, see 62270-62282, 62310-62319)</p> <p>(For sacroiliac joint arthrography, see 27096, 73542. If formal arthrography is not performed and recorded and a formal radiographic report is not issued, use 77003 for fluoroscopic guidance for sacroiliac joint injections)</p> <p>(For paravertebral facet joint injection, see 64490-64495. <u>For paravertebral facet joint nerve destruction by neurolysis, see 64633-64636.</u> For transforaminal epidural needle placement and injection, see 64479-64484)</p> <p>(Do not report 77003 in conjunction with <u>27096</u>, 64479-64484, 64490-64495, <u>64633-64636</u>)</p> <p>(For destruction by neurolytic agent, see 64600-64680)</p> <p>(For percutaneous or endoscopic lysis of epidural adhesions, 62263, 62264 include fluoroscopic guidance and localization)</p>		
Computed Tomography Guidance				
E 77012		<p>Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation</p> <p>(Do not report 77012 in conjunction with <u>27096</u>, 64479-64484, 64490-64495, <u>64633-64636</u>, 0232T)</p>	XXX	1.16 (No Change)

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

CPT Code: 27096 Tracking Number R1 Original Specialty Recommended RVU: **1.52**
Presented Recommended RVU: **1.52**
Global Period: 000 RUC Recommended RVU: **1.48**

CPT Descriptor: Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 37-year-old female presents with a 2 month history of pain rated 6-9/10 in the area of the sacroiliac joint. She has been treating her pain with NSAID's and physical therapy without any significant relief. Her pain is exacerbated with sitting, standing or walking and relieved by lying down. Her physical examination is notable for tenderness to palpation of the left sacroiliac joint and reproduction of her pain with provocative sacroiliac stress tests. Her history and physical examination are consistent with sacroiliac joint pain and she is subsequently scheduled for a diagnostic and therapeutic sacroiliac joint injection with local anesthetic and steroid.

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 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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 45%

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? 33%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Records are reviewed, the patient is examined and consent is obtained. The patient is taken to the fluoroscopy suite and placed prone on the fluoroscopy table.

Description of Intra-Service Work: The area overlying the sacroiliac joint is prepped with betadine and draped. Utilizing intermittent fluoroscopic guidance, the fluoroscopy machine is rotated until the sacroiliac joint is visualized. The skin and subcutaneous tissues are anesthetized with 4cc of 1% lidocaine. A 25 gauge needle is carefully advanced into the joint and verified with various fluoroscopic views and injection of contrast to confirm placement into the joint and tissues. A-P, lateral and oblique spot films are taken and saved. A mixture of local anesthetic and steroid is then injected into the joint and/or periarticular tissues. The needle is removed and the patient is transported to the recovery room for further monitoring and assessment of any pain relief.

Description of Post-Service Work: The patient is closely observed for up to an hour post-procedure in a monitored setting for any new unexpected neurologic deficits and/or any change in vital signs (respiratory depression, bradycardia, altered mental status). A final report is dictated for the patient's medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	Marc Leib, MD, JD, Eduardo Fraifeld, MD, David Carroway, MD, William Sullivan, MD, Chris Merifield, MD, Scott Horn, DO					
Specialty(s):	ASA, AAPM, ASIPP, NASS, ISIS, AAPM&R					
CPT Code:	27096					
Sample Size:	781	Resp N:	55	Response: 7.0 %		
Sample Type:	Panel	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	36.00	75.00	150.00	450.00
Survey RVW:		0.79	1.51	1.52	1.79	2.30
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		2.00	10.00	11.00	15.00	30.00
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: 5 - NF Procedure without sedation/anesthesia care

CPT Code:	27096	Recommended Physician Work RVU: 1.48				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		5.00	0.00	5.00		
Intra-Service Time:		11.00				
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 0.0	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64493	000	1.52	RUC Time

CPT Descriptor 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

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52000	000	2.23	RUC Time	920,676
<u>CPT Descriptor 1</u> Cystourethroscopy (separate procedure)				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
56605	000	1.10	RUC Time	27,933

CPT Descriptor 2 Biopsy of vulva or perineum (separate procedure); 1 lesion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 41.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 27096	<u>Key Reference CPT Code:</u> 64493	<u>Source of Time</u> RUC Time
Median Pre-Service Time	17.00	17.00	
Median Intra-Service Time	11.00	15.00	
Median Immediate Post-service Time	10.00	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	38.00	42.00	
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	3.52	3.27
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.48
--	------	------

Urgency of medical decision making	2.57	2.61
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.87	3.87
--------------------------	------	------

Physical effort required	3.17	3.22
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.22
---	------	------

Outcome depends on the skill and judgment of physician	4.09	4.17
--	------	------

Estimated risk of malpractice suit with poor outcome	3.00	3.17
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.96	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.52	3.52
------------------------------------	------	------

Post-Service intensity/complexity	2.78	2.78
-----------------------------------	------	------

Additional Rationale and Comments

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

This code was revised per a request from the RUC Relativity Assessment Workgroup that the specialties submit a code change proposal to revise the descriptor to include fluoroscopic guidance. The CPT Editorial Panel ultimately approved an option that included the imaging guidance and also arthrography when arthrography is performed.

A straight building block would result in revised code 27096 having a work RVU of 1.664. Prior to these revisions, code 27096 was assigned a work RVU of 1.40. The separately reported fluoroscopic guidance (code 77003) has an RVUw of 0.60. When removing the pre- and post-service work associated with code 77003, we have .264 intra-service work RVUs. (Code 77003 has 10 minutes of pre-service work and 5 minutes of post service work).

$$15 \text{ min} * 0.0224 = 0.336$$

$$0.60 - 0.336 = 0.264$$

Code	Descriptor	Intra-service time	Total time	RVUw
56820	Colposcopy of the vulva;	15	40	1.50
57452	Colposcopy of the cervix including upper/adjacent vagina;	15	40	1.50
58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	10	35	1.53

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) codes 27096 and 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 Anesthesiology

How often? Commonly

Specialty Interventional Pain Management

How often? Commonly

Specialty Physical Medicine & Rehabilitation

How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 169000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Approximately 60% of the Medicare frequency

Specialty Anesthesiology	Frequency 55838	CPT Code: 27096 Percentage 33.04 %
Specialty Interventional Pain Management	Frequency 43839	Percentage 25.94 %
Specialty Physical Medicine & Rehabilitation	Frequency 29406	Percentage 17.40 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 287,649 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. This is based on the 2009 utilization data from the RUC database

Specialty Anesthesiology	Frequency 93090	Percentage 32.36 %
Specialty Interventional Pain Management	Frequency 73064	Percentage 25.40 %
Specialty Physical Medicine & Rehabilitation	Frequency 49010	Percentage 17.03 %

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 27096

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 Committee Recommendation

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

CPT Long Descriptor: Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

Global Period: 000 Meeting Date: April 2011

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 from representatives for the specialty societies convened to review the PE inputs for code 27096 as revised to include imaging guidance and arthrography (when arthrography is performed). The panel included physicians from a wide 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:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The RN/LPN/MTA completes the pre-service diagnostic and referral forms, provides pre-service education and obtains the patient's consent. S/he will also make appropriate follow up phone calls and call in any prescriptions required prior to the procedure.

The Radiology Tech will prepare prior imaging studies for review by the physician.

Intra-Service Clinical Labor Activities:

The RN/LPN/MTA greets the patient, provides gowning and ensures that all appropriate required records are available. S/he will obtain vital signs (to include pulse, BP, temperature, respiration, oxygen saturation). After preparing the room and making certain that all the required equipment/supplies are ready and available, the RN/LPN/MTA will assist the patient with prepping and positioning the patient. The RN/LPN/MTA is in the room throughout the procedure and is solely involved with assistant the physician and monitoring the patient.

The patient is observed for up to one hour after the procedure and we have allocated 25% of this time (15 min) to the RN/LPN/MTA as there will be some degree of multitasking during this time such as the time the RN/LPN/MTA uses to clean the room

AMA/Specialty Society RVS Update Committee Recommendation

The RT will prepare the imaging equipment and input patient and procedure information. The RT positions the C-arm and assists with patient positioning. S/he will performing 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:

Clinical staff will make follow up phone calls to the patient and call in any prescriptions determined to be necessary post-procedure.

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

CPT Long Descriptor: Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

Global Period: 000

Meeting Date: April 2011

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 from representatives for the specialty societies convened to review the PE inputs for code 27096 as revised to include imaging guidance and arthrography (when arthrography is performed). The panel included physicians from a wide 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:

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The RN/LPN/MTA completes the pre-service diagnostic and referral forms and coordinates with the facility re: required pre-surgery services and scheduling of space and equipment. S/he will also obtain the patient's consent, provide pre-service education and make appropriate follow up phone calls and required prescriptions.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F
1	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation			27096 Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed		
		CMS	Staff			
2	LOCATION	Code	Type	Non Facility	Non Facility	Facility
3	GLOBAL PERIOD			000	000	000
4				L041B	L037D	L037D
5				Rad Tech	RN/LPN/ MTA	RN/LPN/ MTA
6	TOTAL CLINICAL LABOR TIME			23.0	48.0	15.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			3.0	6.0	12.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			20.0	39.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	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				3	3
13	Coordinate pre-surgery services					3
14	Schedule space and equipment in facility					3
15	Provide pre-service education/obtain consent				3	3
16	Follow-up phone calls & prescriptions				0	0
17	Other Clinical Activity (please specify) Pull and hang prior imaging studies for MD to review			3		
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				3	
22	Obtain vital signs				5	
23	Prepare room, equipment, supplies			2	0	
24	Prepare and position patient/ monitor patient/ set up IV			2	2	
25	Intra-service					
26	Assist physician in performing procedure			11	11	
27	Post-Service					
28	Monitor pt. following service/check tubes, monitors, drains				15	
29	Clean room/equipment by physician staff			3	3	
30	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				0	
31	Other Clinical Activity (please specify) Process, hand, file films and review study with interpreting MD			2		
32	End: Patient leaves office					
33	POST-SERVICE Period					
34	Start: Patient leaves office/facility					
35	Conduct phone calls/call in prescriptions				3	3
36	End: with last office visit before end of global period					
37	MEDICAL SUPPLIES		Unit			
38	Pack, basic injection	SA041	1			
39	Pack, minimum multi specialty visit	SA048	1			
40	Drape, sterile, c-arm, fluoro	SB008	1			
41	Needle, 18-26g 1.5-3.5in, spinal	SC028	1			
42	Syringe 10-12 ml	SC051	1			
43	Bupivacaine 0.25% inj (Marcaine)	SH021	5cc			
44	Film, dry, radiographic, 8 in x 10in	SK025	2			
45	Equipment		Min			
46	Stretcher	EF018	39			
47	Room, mobile C-ARM	EL018	18			
48	X-ray view box, 4 panel	ER067	18			
49	Printer, laser, paper	ED032	0			

	A	B	C	D	E	F
1	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation			27096 Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed		
		CMS	Staff			
2	LOCATION	Code	Type	Non Facility	Non Facility	Facility
3	GLOBAL PERIOD			000	000	000
4				L041B	L037D	L037D
5				Rad Tech	RN/LPN/ MTA	RN/LPN/ MTA
6	TOTAL CLINICAL LABOR TIME			23.0	50.0	15.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			3.0	6.0	12.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			20.0	41.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	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				3	3
13	Coordinate pre-surgery services					3
14	Schedule space and equipment in facility					3
15	Provide pre-service education/obtain consent				3	3
16	Follow-up phone calls & prescriptions				0	0
17	Other Clinical Activity (please specify) Pull and hang prior imaging studies for MD to review			3		
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				3	
22	Obtain vital signs				5	
23	Prepare room, equipment, supplies			2	2	
24	Prepare and position patient/ monitor patient/ set up IV			2	2	
25	Intra-service					
26	Assist physician in performing procedure			11	11	
27	Post-Service					
28	Monitor pt. following service/check tubes, monitors, drains				15	
29	Clean room/equipment by physician staff			3	3	
30	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				0	
31	Other Clinical Activity (please specify) Process, hand, file films and review study with interpreting MD			2		
32	End: Patient leaves office					
33	POST-SERVICE Period					
34	Start: Patient leaves office/facility					
35	Conduct phone calls/call in prescriptions				3	3
36	End: with last office visit before end of global period					
37	MEDICAL SUPPLIES		Unit			
38	Pack, basic injection	SA041	1			
39	Pack, minimum multi specialty visit	SA048	1			
40	Drape, sterile, c-arm, fluoro	SB008	1			
41	Needle, 18-26g 1.5-3.5in, spinal	SC028	1			
42	Syringe 10-12 ml	SC051	1			
43	Bupivacaine 0.25% inj (Marcaine)	SH021	5cc			
44	Film, dry, radiographic, 8 in x 10in	SK025	2			
45	Equipment		Min			
46	Stretcher	EF018	60			
47	Room, mobile C-ARM	EL018	18			
48	X-ray view box, 4 panel	ER067	18			
49	Printer, laser, paper	ED032	18			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

October 2010

Multi-Layer Compression System

In June 2010, the CPT Editorial Panel revised code 29581 and created three new codes to describe the application of multi-layer compression to the upper and lower extremities, not just below the knee. Multi-layer compression systems are used to treat edema for a variety of indications, not just venous leg ulcers.

29581

The CPT Editorial Panel determined the revisions to the descriptor for 29581 were editorial when multi-layer compression codes for other body areas were created. Additionally, no changes were made to the vignette and therefore the specialty society explained that resurveying this code was not necessary. The RUC agreed that the changes to 29581 were editorial. The RUC noted that code 29581 was intended predominantly for venous ulcer therapy and includes ulcer related care in addition to compression. **The RUC recommends that the changes to 29581 were editorial and to maintain the work RVU of 0.60 for CPT code 29581.**

CPT Code (●New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
29540		Strapping; ankle and/or foot (Do not report 29540 in conjunction with 29581, <u>29582</u>)	000	0.51 (No Change)
29580		Unna boot (Do not report 29580 in conjunction with 29581, <u>29582</u>)	000	0.55 (No Change)
▲29581	A1	Application of multi-layer venous wound compression system, below knee ; <u>leg (below knee), including ankle and foot</u> (Do not report 29581 in conjunction with 29540, 29580, <u>29582</u> , 36475, 36478, 97140)	000	0.60 (No Change)

CPT Code (●New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
●29582	A2	thigh and leg, including ankle and foot, when performed <u>(Do not report 29582 in conjunction with 29540, 29580, 29581, 36475, 36478, 97140)</u>	000	0.35 (HCPAC Recommendation)
●29583	A3	upper arm and forearm <u>(Do not report 29583 in conjunction with 29584, 97140)</u>	000	0.25 (HCPAC Recommendation)
●29584	A4	upper arm, forearm, hand, and fingers (Do not report 29584 in conjunction with 29583, 97140)	000	0.35 (HCPAC Recommendation)

August 24, 2010

Barbara Levy, MD
Chair, AMA/Specialty Society Relative Value Scale Update Committee
American Medical Association
515 N. State St.
Chicago, IL 60610

Dear Dr. Levy:

CPT code 29581 (Application of multi-layer venous wound compression system, below knee) was evaluated by the CPT Editorial panel in June 2010 along with 3 new CPT codes in the same family. The RUC originally asked the specialties to bring to the October 2010 RUC meeting a work RVU recommendation on all four of these CPT codes. However, at its June 2010 meeting, the CPT Editorial Panel's final determination was that that the recent code description changes to CPT code 29581 were editorial and no changes were made to the typical patient vignette, so revaluing of this CPT code was not necessary. Therefore, the specialties determined that a survey and recommendation of CPT code 29581 was not required.

Sincerely,



Gary Seabrook, MD
SVS RUC Advisor



Sean Roddy, MD
SVS CPT Advisor

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment – Codes Reported Together 75% or More Screen

April 2011

Shoulder Arthroscopy - Decompression of Subacromial Space

In February 2010, CPT code 29826 was identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. This service is commonly performed with codes 29824, 29827 and 29828. In addition, as part of the Fourth Five-Year Review, CMS identified 29826 as a Harvard reviewed code with utilization over 30,000. Given that the service is rarely performed as a stand alone procedure (less than 1% of the time), the American Academy of Orthopaedic Surgeons (AAOS) sent CMS a request to change the global period from 090 to ZZZ. CMS agreed and CPT code 29826 was surveyed and presented as an add-on service with a ZZZ global period service.

29826 Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coraco-acromial ligament (ie, arch) release, when performed

The RUC reviewed the survey results from 47 orthopaedic surgeons for CPT code 29826. The RUC agreed with the median intra-service time of 40 minutes. The RUC discussed the current value of this add-on service as it will change from a 090 global service and will no longer include the additional approach and closure physician time, or post-operative work. Current reporting of 29826 as a 090-day global code is subject to the multiple endoscopy payment rule, and when reported with another arthroscopy procedure, would have a work RVU of 3.13 under the payment rule. The specialty society did not have compelling evidence to support a change in the work value of the procedure, so the RUC and specialty agreed that a work RVU of 3.00, the survey's 25th percentile, is an accurate value of the physician work for the surveyed procedure.

To further justify this value, the RUC reviewed CPT code 43283 *Laparoscopy, surgical, esophageal lengthening procedure* (work RVU= 2.95). The RUC agreed that the services are similar add-on codes with identical intra-service times, 40 minutes, and should be valued closely. Additionally, the RUC compared 29826 to code 62160 *Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage* (work RVU= 3.00) and agreed that the services, with identical intra-service time of 40 minutes and similar intensity and complexity, should be valued identically. **The RUC recommends a work RVU of 3.00 for CPT code 29826.**

Work Neutrality

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

Practice Expense

The RUC made no revisions to the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
29824	S1	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)	090	8.98 (No Change)
▲ +29826	S2	decompression of subacromial space with partial acromioplasty, with coracoacromial or without ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure) (Use 29826 in conjunction with 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29827, 29828)	090 ZZZ	3.00
29827	S3	Arthroscopy, shoulder, surgical; with rotator cuff repair	090	15.59 (No Change)
29828	S4	biceps tenodesis	090	13.16 (No Change)

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

CPT Code: 29826 Tracking Number S2 Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **4.00**
Global Period: ZZZ RUC Recommended RVU: **3.00**

CPT Descriptor: Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coraco-acromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 40-year-old female tennis player presents with a four-month history of shoulder pain. The symptoms are worse at night, with overhead activity and are affecting her daily activities. On physical exam she has pain on palpation of the greater tuberosity, restricted range of motion and weakness on muscle testing. An impingement test is positive. X-rays are normal and an MRI reveals rotator cuff tendinosis. A subacromial corticosteroid injection and physical therapy afford transient relief. She undergoes arthroscopic subacromial decompression with partial acromioplasty, in addition to other reconstructive procedure[s].

Please note: This is an add-on code. For purpose of this survey consider ONLY the additional physician work. The primary procedure(s) would be reported separately.

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 , In the ASC , In the office

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day , Kept overnight (less than 24 hours) , Admitted (more than 24 hours)

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

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?

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?

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: The subacromial bursa is accessed via the posterior portal which reveals some fraying of the coracoacromial ligament accompanied by a bursal-side partial thickness rotator cuff tear. A lateral arthroscopic portal is developed and bursal tissue and the bursal side cuff is debrided for visualization. The coracoacromial ligament is released with a radiofrequency device. The arthroscope is placed in the lateral portal and an acromioplasty is performed using a bone-block technique from posterior to anterior with a motorized bone-cutting shaver. Hemostasis is obtained with a radiofrequency device.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	William Creevy, MD; Louis McIntyre, MD					
Specialty(s):	AAOS; AANA;					
CPT Code:	29826					
Sample Size:	450	Resp N:	47	Response: 10.4 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	40.00	50.00	100.00	300.00
Survey RVW:		1.40	3.00	4.00	4.63	9.93
Pre-Service Evaluation Time:				5.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		15.00	28.00	40.00	45.00	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:

ZZZ Global Code

CPT Code:	29826	Recommended Physician Work RVU: 3.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		40.00		
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22525	ZZZ	4.45	RUC Time

CPT Descriptor 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)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22525	ZZZ	4.45	RUC Time	13,121

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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
	090		RUC Time	

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
	ZZZ		RUC Time

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: 7 % of respondents: 14.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 29826	<u>Key Reference CPT Code:</u> 22525	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	40.00	40.00	
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	40.00	40.00
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	3.57	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.71	3.57
Urgency of medical decision making	2.71	3.14

Technical Skill/Physical Effort (Mean)

Technical skill required	4.14	4.29
Physical effort required	3.86	3.86

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.43	4.00
Outcome depends on the skill and judgment of physician	4.00	3.86
Estimated risk of malpractice suit with poor outcome	3.71	3.86

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.71	3.71
Intra-Service intensity/complexity	4.14	4.43
Post-Service intensity/complexity	3.43	3.57

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUR 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 29826 was identified by CMS through the "Harvard-Valued - Utilization Over 30,000" screen. CMS requested review of 29826 as part of the fourth 5-Year-Review process and the AAOS conducted a survey for the September 2010

RUC of 29826 as a 090 global code. However, because 29826 was also on the CMS screen for “billed with other codes more than 75% of the time”, the RUC recommended to AAOS that 29826 be converted to an add-on code to be appended to the base shoulder codes. The AAOS complied with this request and presented a code change proposal to the CPT Editorial Panel at the February 2011 CPT Editorial Panel meeting changing 29826 to an add-on code.

Pre-time

No pre time assigned as this is a ZZZ code

Comparison to key reference code

Key reference code 22525

	RVW	Total Time	Eval	Posit	SDW	INTRA	IM-post	facility	office	IWPUT
22525	4.45	40	0	0	0	40	0	0	0	0.112
29826	3.00	40	0	0	0	0	0	0	0	0.100

The work involved in 22525 and 29826 are comparable. Both are performed percutaneously through puncture wounds. Both require indirect visualization of the anatomic structures instrumented; 22525 with fluoroscopy and 29826 with arthroscopy. Surrounding joint, nervous and vascular structures must be avoided in both procedures. Finally, both require bony ablation, sculpting and removal for completion.

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. 29824, 29827, 29828

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 29826

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 Orthopaedics 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.

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?

72,991 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2009 Medicare utilization file shows 29826 was reported 75,461 as a 090 global code. However, it was reported along with 29824, 29827 and 29828 97.63% of the time. Therefore, it was reported stand-alone 2.37% of the time. $2.37\% \text{ of } 75,461 = 2,470$ and as such we subtracted 2,470 from 75,461 to arrive at our estimated Medicare utilization for 29826 as an add-on code

Specialty orthopaedics	Frequency 71261	Percentage 97.62 %
------------------------	-----------------	--------------------

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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 29826

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 Update Process
Practice Expense Summary of Recommendation
ZZZ Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

29826, Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coraco-acromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)

Global Period *ZZZ*

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 discussed the practice expense requirements for 29826 and determined that the standard 90-day global inputs would apply.

This is a facility only *ZZZ* code and thus has no PE inputs.

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
1	AMA/Specialty Society RVS Update Committee Recommendation				
2				29826	
3	Meeting Date: April, 2011 Specialty: AAOS Tab 7			Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release	
4	Table, power	Code	Staff Type	OFF	FAC
5	GLOBAL PERIOD			ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0
10	PRE-SERVICE				
11	Start: Following visit when decision for surgery or procedure made				
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	0	0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	0	0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0	0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0	0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	0	0
17	Other Clinical Activity:coordination of care	L037D	RN/LPN/MTA	0	0
18	End:When patient enters office/facility for surgery/procedure				
19	SERVICE PERIOD				
20	Start: When patient enters site for procedure: Services Prior to Procedure				
39	Discharge day management	L037D	RN/LPN/MTA	0	0
41	End: Patient leaves office				
42	POST-SERVICE Period				
43	Start: Patient leaves office/facility				
44	Conduct phone calls/call in prescriptions				
45	Office visits:				
46	List Number and Level of Office Visits				
47	99211 16 minutes		16		
48	99212 27 minutes		27		
49	99213 36 minutes		36	0	0
50	99214 53 minutes		53		
51	99215 63 minutes		63		
52	Other				
53	Total Office Visit Time	L037D	RN/LPN/MTA	0	0
54	Other Total:				
55	End: with last office visit before end of global period				
56	MEDICAL SUPPLIES	Code	Unit		
57	pack, minimum multi-specialty visit	SA048	pack	0	0
58	pack, post-op incision care (suture & staple)	SA053	pack	0	0
59	Equipment	Code			
60	table, power	EF031		0	0
61	light, surgical	EF014		0	0

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Fourth Five-Year Review

April 2011

Arthroscopic Meniscectomy of Knee

In the 4th Five-Year Review of the RBRVS, CMS identified codes 29880 and 29881 through the Harvard-Valued – Utilization over 30,000 screen. CMS requested a review of these codes and the specialty's requested a referral to CPT in order to revise the code descriptors to include chondroplasty in any compartment of the knee as this is typically how the condition is currently treated. In September 2010, the RUC agreed to this code change recommendation and in February 2011 the CPT Editorial Panel changed the code descriptors of 29880 and 29881 to include the work of chondroplasty.

29880 Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s) when performed

The RUC reviewed the survey results from 67 orthopaedic, hip, and knee surgeons who perform these types of services. The current work RVU of 9.45 was supported by the survey. However, the specialty understood the survey results overstated the total physician work of this service in comparison to reference procedures requiring similar work.

The RUC agreed with the physician time components from the specialty survey (pre-service = 58, intra-service = 45, post-service 15, ½ 99238, 2 x 99213, 1 x 99212) with 7 additional minutes necessary for pre-service positioning as the patient is positioned supine in a leg holder with application of a tourniquet.

The RUC, using magnitude estimation, compared 29880 to the recently RUC valued code 23120 *Claviclectomy; partial* (work RVU = 7.39, intra-service time = 45 minutes), as it is a good comparator cross-walk code, requiring similar physician total work. The RUC agreed with the similarity in overall work effort involved in these two services. The RUC agreed that the intensity and complexity of 29880 was higher than 23120, offsetting the one post operative visit differential. **The RUC recommends a work RVU of 7.39 for CPT code 29880.**

29881 Arthroscopy, knee, surgical; for infection, with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s) when performed

The RUC reviewed the survey results from 67 orthopaedic, hip, and knee surgeons who perform these types of services. The current work RVU of 8.71 was supported by the survey. However, the specialty understood the survey results overstated the total physician work of this service in comparison to reference procedures requiring similar work.

The RUC agreed with the physician time components from the specialty survey (pre-service = 58, intra-service = 40, post-service 15, ½ 99238, 2 x 99213, 1 x 99212) with 7 additional minutes necessary for pre-service positioning as the patient is positioned supine in a leg holder with application of a tourniquet.

The RUC, using magnitude estimation compared 29881 to the recently valued code 26715 *Open treatment of metacarpophalangeal dislocation, single, includes internal fixation, when performed* (work RVU = 7.03, intra-service time = 40 minutes), as it is an appropriate cross-walk. The RUC agreed with the similarity in overall work effort involved in these two services. The RUC agreed that the intensity and complexity of 29881 is higher than 29715, offsetting the one post operative visit differential. **The RUC recommends a work RVU of 7.03 for CPT code 29881.**

Work Neutrality

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

Practice Expense: The RUC accepted the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Musculoskeletal System Endoscopy/Arthroscopy				
29871		Arthroscopy, knee, surgical; for infection, lavage and drainage	090	6.69 (No Change)
E 29877		debridement/shaving of articular cartilage (chondroplasty) (When performed with arthroscopic meniscectomy, see 29880 or 29881)	090	8.30 (No Change)
▲29880	T1	with meniscectomy (medial AND lateral, including any meniscal shaving) <u>including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s) when performed</u>	090	7.39
▲29881	T2	with meniscectomy (medial OR lateral, including any meniscal shaving) <u>including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s) when performed</u>	090	7.03

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

CPT Code:29880 Tracking Number Original Specialty Recommended RVU: **7.39**
Presented Recommended RVU: **7.39**
Global Period: 090 RUC Recommended RVU: **7.39**

CPT Descriptor: Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s) when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old woman presents with a two-month history of pain and swelling of her right knee. She cannot recall any specific trauma. On physical examination she walks with a limp. There is an effusion with medial and lateral joint line tenderness. Flexion of the knee is restricted and produces pain. X-rays show medial joint space narrowing and an MRI reveals medial and lateral meniscal tears. Despite rest and anti-inflammatory medication the pain and disability persist, affecting daily living activities. A corticosteroid injection and physical therapy afford only transient relief. She undergoes arthroscopic medial and lateral meniscectomies with chondral debridement of the patella, trochlea, and medial and lateral femoral condyles.

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 33% , In the ASC 66%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

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. 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. A tourniquet is placed on the leg. Monitor/assist with patient positioning – using a mechanical leg holder to support the upper thigh and facilitate movement and exposure of the knee. Pads are placed to protect areas from pressure. Position of the extremities and head are checked and adjusted. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. The leg is exsanguinated.

Description of Intra-Service Work: Under anesthesia, anteromedial and anterolateral portals are introduced and a diagnostic arthroscopy reveals knee synovitis. A limited synovectomy is performed for visualization. There are chondral changes on patella, trochlea, and the medial femoral condyle with a complex tear of the medial meniscus. The cruciate ligaments are normal and the lateral joint line shows degenerative changes with a horizontal tear of the lateral meniscus. The meniscal tears are probed and then removed with basket forceps and a motorized shaver back to a rim of stable tissue. The chondral

lesions are then debrided to stable cartilage. The instrumentation is removed, tourniquet let down, and the wounds are closed.

Description of Post-Service Work: Post-service work: in facility:

Application of dressing. Monitor patient stabilization in the recovery room. Consultation with the family and patient regarding the surgery and postoperative regimen. Communication with health care professionals including written and oral reports and orders. Postoperative care is coordinated with recovery room nursing staff. The patient's vital signs are checked. The circulation, sensation, and motor function of the operated extremity are assessed. Home restrictions (ie, activity, bathing) are discussed with the patient and family members. Write prescriptions for medications needed post-discharge. Dictation of an operative report. Procedure note is written in the patient chart. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office:

Examine and talk with patient. Review intra-operative images or video with patient and family. Answer patient/family questions. Assessment of surgical wounds. Remove sutures. Assess circulation, sensation, and motor function of the operated extremity. Redress wound. Order physical therapy. Assess ROM, swelling, and muscle function. Supervision of rehabilitation. Discuss progress with PCP (verbal and written). Write medication prescriptions. Complete work status and disability forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	William Creevy, MD; Louis McIntyre, MD; Brian Parsley, MD				
Specialty(s):	AAOS; AANA; AAHKS				
CPT Code:	29880				
Sample Size:	600	Resp N:	67	Response: 11.1 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	15.00	25.00	50.00
Survey RVW:		6.00	9.72	10.50	12.00
Pre-Service Evaluation Time:				35.00	
Pre-Service Positioning Time:				10.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		30.00	38.00	45.00	45.00
Immediate Post Service-Time:	15.00				
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):	62.00	99211x 0.00	12x 1.00	13x 2.00	14x 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:	29880	Recommended Physician Work RVU: 7.39		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		10.00	3.00	7.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		45.00		
Immediate Post Service-Time:	15.00			
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):	62.00	99211x 0.00	12x 1.00	13x 2.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
29906	090	9.65	RUC Time

CPT Descriptor Arthroscopy, subtalar joint, surgical; with debridement**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
49585	090	6.59	RUC Time	22,938

CPT Descriptor 1 Repair umbilical hernia, age 5 years or older; reducible

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
67904	090	7.97	RUC Time	50,099

CPT Descriptor 2 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
23120	090	7.39	RUC Time

CPT Descriptor Claviclectomy; partial**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 16.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 29880	<u>Key Reference CPT Code:</u> 29906	<u>Source of Time</u> RUC Time
Median Pre-Service Time	58.00	65.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	62.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	199.00	244.00	
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	3.00
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.10
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Urgency of medical decision making	2.36	2.20
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.27	3.20
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Physical effort required	3.00	2.80
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.73	2.70
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Outcome depends on the skill and judgment of physician	3.45	3.30
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Estimated risk of malpractice suit with poor outcome	2.27	2.30
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.91	3.10
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Intra-Service intensity/complexity	3.18	3.00
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Post-Service intensity/complexity	2.91	3.00
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT 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 29880 was identified by CMS through the "Harvard-Valued - Utilization Over 30,000" screen. CMS requested review of 29880 as part of the fourth 5-Year-Review process and the AAOS and AAHKS surveyed 29880 for the September 2010 RUC meeting. At that meeting, the AAOS and AAHKS requested referral to CPT in order to revise the code descriptor to include chondroplasty in any compartment of the knee as this is typically how the condition is currently treated. The RUC agreed and the AAOS presented a code change recommendation at the February 2011 CPT Editorial

Panel meeting. This new code includes the work of removing the menisci as well as any chondroplasty work done in any compartment of the knee; work that was previously billed separately either as G0289 (Medicare and some private payers) or 29877. The CPT Editorial Panel accepted the recommendation and we surveyed the new code for the April 2011 RUC meeting.

Work RVU Recommendation

A RUC survey of general orthopaedic surgeons, arthroscopic orthopaedic surgeons, and hip and knee orthopaedic surgeons was conducted and 67 responses from experienced surgeons were received. We recommend a **work RVU of 7.39 RVW** which is 2.06 work RVUs less than the current value of 29880-9.45.

Using 2009 Medicare utilization figures, the total frequency for 29880 was 55,147. A 2.06 RVW reduction results in a total RVW savings to Medicare of 113,603 RVW, which when multiplied by a conversion factor of 33.9764, equals approximately a savings to Medicare of \$3,859,815 and that doesn't include the additional funds saved by not paying G0289, nor does it include any reductions to the PE RVUs that might result.

Pre-time

Pre-time package 3 (Straightforward Patient/Difficult Procedure) is selected. We added 7 minutes to positioning as the patient is positioned supine in a leg holder with application of a tourniquet. This is consistent with other arthroscopic knee procedures.

Comparison to key reference code

	RVW	Total Time	Eval	Posit	SDW	INTRA	IM-post	facility	office	IWPUT
29906	9.65	244	40	15	15	60	15	.5-99238	1-99212 3-99213	0.066
29880	7.39	206	33	10	15	45	15	.5-99238	3-99213	0.054

Our key reference service of 29906, *Arthroscopy, subtalar joint, surgical; with debridement* has more total time (244 minutes compared to 206 minutes) than our recommended times for 29880. It has 7 more minutes of pre-service evaluation time, 15 more minutes of intra-service time, and one additional level 99212 post-operative office visit. Its value is 2.26 greater than our recommended RVW for 29880 and it has a higher IWPUT than our recommended value for 29880.

Comparison to MPC codes

	RVW	Total Time	Eval	Posit	SDW	INTRA	IM-post	facility	office
49585	6.59	178	45			45	30	.5-99238	1-99212 1-99213
29880	7.39	206	33	10	15	45	15	.5-99238	3-99213
67904	7.97	185	35			45	15	.5-99238	3-99212 1-99213

Additional comparative code

	RVW	Total Time	Eval	Posit	SDW	INTRA	IM-post	facility	office	IWPUT
23120	7.39	227	40	15	15	45	15	.5-99238	2-99212 2-99213	0.048
29880	7.39	206	33	10	15	45	15	.5-99238	3-99213	0.054

It was the consensus opinion of the expert panel that the 25th percentile and median survey wRVUs were too high.

Our rationale for our recommended work RVU of 7.39 is based on magnitude estimation with 23120, *Claviclectomy; partial*. 23120 was on our reference service list and was surveyed and valued by the RUC in 2008 as part of the CMS screen for site-of-service anomalies (where its value was reduced from its previous value). It has 227 total minutes, but like 29880 has 45 minutes intra-service time which makes it an appropriate crosswalk for our recommended value. Our

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 55,147 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. 2009 Medicare utilization file

Specialty orthopaedics	Frequency 54562	Percentage 98.93 %	
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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 29880

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:29881	Tracking Number	Original Specialty Recommended RVU: 7.12
		Presented Recommended RVU: 7.12
Global Period: 090		RUC Recommended RVU: 7.03

CPT Descriptor: Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s) when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man presents with pain and swelling, of the left knee after stepping in a hole while playing golf. On physical examination, he walks with a limp. There is an effusion in the knee with medial joint line tenderness. Flexion of the knee is restricted and produces pain. Weight bearing X-rays show medial joint space narrowing and subchondral sclerosis. An MRI reveals a medial meniscal tear. Despite rest, anti-inflammatory medication, and physical therapy, the pain and disability persist, affecting daily living activities. He undergoes arthroscopic medial meniscectomy with chondral debridement of the patella, trochlea, and medial femoral condyle.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 34% , In the ASC 64%, In the office 1%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

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. 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. A tourniquet is placed on the leg. Monitor/assist with patient positioning – using a mechanical leg holder to support the upper thigh and facilitate movement and exposure of the knee. Pads are placed to protect areas from pressure. Position of the extremities and head are checked and adjusted. Indicate areas of skin to be prepped and mark surgical incisions. Scrub and gown. Perform surgical "time out" with operating surgical team. The leg is exsanguinated.

Description of Intra-Service Work: Under anesthesia, anteromedial and anterolateral portals are introduced and a diagnostic arthroscopy reveals knee synovitis. A limited synovectomy is performed for visualization. There are chondral changes on the patella, trochlea, and medial femoral condyle with a flap tear of the medial meniscus. The cruciate ligaments and lateral joint line are normal. The meniscal tear is probed and then removed with basket forceps and a motorized shaver back to a rim of stable tissue. The chondral lesions are debrided back to stable cartilage. The instrumentation is removed, tourniquet let down, and the wounds are closed.

Description of Post-Service Work: Post-service work: in facility:

Application of dressing. Monitor patient stabilization in the recovery room. Consultation with the family and patient regarding the surgery and postoperative regimen. Communication with health care professionals including written and oral reports and orders. Postoperative care is coordinated with recovery room nursing staff. The patient's vital signs are checked. The circulation, sensation, and motor function of the operated extremity are assessed. Home restrictions (ie, activity, bathing) are discussed with the patient and family members. Write prescriptions for medications needed post-discharge. Dictation of an operative report. Procedure note is written in the patient chart. All appropriate medical records are completed, including discharge summary and discharge instructions, and insurance forms.

Post-service work: in office:

Examine and talk with patient. Review intra-operative images or video with patient and family. Answer patient/family questions. Assessment of surgical wounds. Remove sutures. Assess of circulation, sensation, and motor function of the operated extremity. Redress wound. Order physical therapy. Assess ROM, swelling, and muscle function. Supervision of rehabilitation. Discuss progress with PCP (verbal and written). Write medication prescriptions. Complete work status and disability forms.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	William Creevy, MD; Louis McIntyre, MD; Brian Parsley, MD				
Specialty(s):	AAOS; AANA; AAHKS				
CPT Code:	29881				
Sample Size:	600	Resp N:	67	Response: 11.1 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	35.00	50.00	90.00
Survey RVW:		6.00	9.12	10.00	11.00
Pre-Service Evaluation Time:				35.00	
Pre-Service Positioning Time:				10.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		20.00	30.00	40.00	45.00
Immediate Post Service-Time:		15.00			
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):	62.00	99211x 0.00	12x 1.00	13x 2.00	14x 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:	29881	Recommended Physician Work RVU: 7.03		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		10.00	3.00	7.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		40.00		
Immediate Post Service-Time:		15.00		
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):	62.00	99211x 0.00	12x 1.00	13x 2.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
29906	090	9.06	RUC Time

CPT Descriptor Arthroscopy, subtalar joint, surgical; with debridement**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
49585	090	6.59	RUC Time	22,398

CPT Descriptor 1 Repair umbilical hernia, age 5 years or older; reducible

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
67904	090	7.97	RUC Time	50,099

CPT Descriptor 2 Repair of blepharoptosis; (tarso) levator resection or advancement, external approach

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
23120	090	7.39	RUC Time

CPT Descriptor Claviclectomy; partial**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 16.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 29881	<u>Key Reference CPT Code:</u> 29906	<u>Source of Time</u> RUC Time
Median Pre-Service Time	58.00	65.00	
Median Intra-Service Time	40.00	60.00	
Median Immediate Post-service Time	15.00	15.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	19.0	19.00	
Median Office Visit Time	62.0	85.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	194.00	244.00	
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	3.09	3.00
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
--	------	------

Urgency of medical decision making	2.36	2.27
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.45	3.36
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Physical effort required	3.00	2.82
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.45	2.55
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Outcome depends on the skill and judgment of physician	3.27	3.09
--	------	------

Estimated risk of malpractice suit with poor outcome	2.18	2.18
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.82	3.00
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Intra-Service intensity/complexity	3.09	3.00
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Post-Service intensity/complexity	2.55	2.55
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Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT 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 29881 was identified by CMS through the "Harvard-Valued - Utilization Over 30,000" screen. CMS requested review of 29881 as part of the fourth 5-Year-Review process and the AAOS, AAHKS and AANA surveyed 29880 for the September 2010 RUC meeting. At that meeting, the AAOS, AAHKS and AANA requested referral to CPT in order to revise the code descriptor to include chondroplasty in any compartment of the knee as this is typically how the

condition is currently treated. The RUC agreed and the AAOS presented a code change recommendation at the February 2011 CPT Editorial Panel meeting. This new code includes the work of removing the meniscus as well as any chondroplasty work done in any compartment of the knee; work that was previously billed separately either as G0289 (Medicare and some private payers) or 29877. The CPT Editorial Panel accepted the recommendation and we surveyed the new code for the April 2011 RUC meeting.

Work RVU Recommendation

A RUC survey of general orthopaedic surgeons, arthroscopic orthopaedic surgeons, and hip and knee orthopaedic surgeons were conducted and 67 responses from experienced surgeons was received.

Pre-time

Pre-time package 3 (Straightforward Patient/Difficult Procedure) is selected. We added 7 minutes to positioning as the patient is positioned supine in a leg holder with application of a tourniquet. This is consistent with other arthroscopic knee procedures.

Comparison to key reference code

	RVW	Total Time	Eval	Posit	SDW	INTRA	IM-post	facility	office	IWPUT
29906	9.65	244	40	15	15	60	15	.5-99238	1-99212 3-99213	0.066
29881	7.12	201	33	10	15	40	15	.5-99238	3-99213	0.054

Our key reference service of 29906, *Arthroscopy, subtalar joint, surgical; with debridement* has more total time (244 minutes compared to 201 minutes) than our recommended times for 29881. It has 7 more minutes of pre-service evaluation time, 20 more minutes of intra-service time, and one additional level 99212 post-operative office visit. Its value is 2.53 greater than our recommended RVW for 29881 and it has a higher IWPUT than our recommended value for 29881.

Comparison to MPC codes

	RVW	Total Time	Eval	Posit	SDW	INTRA	IM-post	facility	office
49585	6.59	178	45			45	30	.5-99238	1-99212 1-99213
29880	7.12	201	33	10	15	40	15	.5-99238	3-99213
67904	7.97	185	35			45	15	.5-99238	3-99212 1-99213

It was the consensus opinion of the expert panel that the 25th percentile and median survey wRVUs were too high.

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) 29881

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 Orthopaedics 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.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

72,945 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2009 Medicare utilization file

Specialty orthopaedics	Frequency 72237	Percentage 99.02 %
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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 29881

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 Update Process
PERC Summary of Recommendation
010 or 090 Day Global Periods
Facility Direct Inputs

CPT Long Descriptor:

29880, Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

29881, Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

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

A consensus panel of experts representing orthopaedics reviewed the practice expense details for the survey codes relative to other facility-only 90-day global orthopaedic services.

Please describe the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No changes were made to the standard pre-service times. A total of 60 (facility) minutes has been applied for the pre-service clinical labor activities. During the pre-service period, clinical staff conducts the standard pre-service activities: An RN/LPN/MA completes pre-service diagnostic and referral forms, coordinates pre-surgery services, schedules space and equipment in facility, provides pre-service education/obtains consent, and conducts follow-up phone calls.

Intra-Service Clinical Labor Activities:

Standard times for the activities necessary in the office and 100% of physician time were applied.

The standard 6 minutes has been applied for the inpatient procedure for half-day discharge management services from the facility.

Post-Service Clinical Labor Activities:

The standard times have been applied for post-service clinical labor time.

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			29880		29881	
2	Meeting Date: April 2011 Specialty: AAOS, AAHKS Tab 8			Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed		Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed	
3	LOCATION	Code	Staff Type	Office	Facility	Office	Facility
4	GLOBAL PERIOD			090	090	090	090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	165	N/A	165
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	60	N/A	60
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	6	N/A	6
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	N/A	99	N/A	99
9	PRE-SERVICE						
10	Start: Following visit when decision for surgery or procedure made						
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7
17	End: When patient enters office/facility for surgery/procedure						
18	SERVICE PERIOD						
39	Discharge day management 99238 --12 minutes	L037D	RN/LPN/MTA		6		6
41	End: Patient leaves office/FACILITY						
42	POST-SERVICE Period						
43	Start: Patient leaves office/facility						
44	Conduct phone calls/call in prescriptions						
46	<i>List Number and Level of Office Visits</i>						
47	99211 16 minutes		16				
48	99212 27 minutes	L037D	27		1		1
49	99213 36 minutes	L037D	36		2		2
50	99214 53 minutes		53				
51	99215 63 minutes		63				
52	Other						
54	<i>Total Office Visit Time</i>				99		99
55	Other Activity (please specify)						
56	End: with last office visit before end of global period						
57	MEDICAL SUPPLIES	CMS Code	Unit				
58	pack, minimum multi-specialty visit	SA048	pack		3		3
59	pack, post-op incision care (suture)	SA054	kit		1		1
60							
61							
62	Equipment	CMS Code	Utilization Percentage				
63	table, power	EF031	100%		99		99
64	light, exam	EQ168	100%		99		99

Typical Patient (29880)

A 60-year-old woman presents with a two-month history of pain and swelling of her right knee. She cannot recall any specific trauma. On physical examination she walks with a limp. There is an effusion with medial and lateral joint line tenderness. Flexion of the knee is restricted and produces pain. X-rays show medial joint space narrowing and an MRI reveals medial and lateral meniscal tears. Despite rest and anti-inflammatory medication the pain and disability persist, affecting daily living activities. A corticosteroid injection and physical therapy afford only transient relief. She undergoes arthroscopic medial and lateral meniscectomies with chondral debridement of the patella, trochlea, and medial and lateral femoral condyles.

Typical Patient (29881)

A 60-year-old man presents with pain and swelling, of the left knee after stepping in a hole while playing golf. On physical examination, he walks with a limp. There is an effusion in the knee with medial joint line tenderness. Flexion of the knee is restricted and produces pain. Weight bearing X-rays show medial joint space narrowing and subchondral sclerosis. An MRI reveals a medial meniscal tear. Despite rest, anti-inflammatory medication, and physical therapy, the pain and disability persist, affecting daily living activities. He undergoes arthroscopic medial meniscectomy with chondral debridement of the patella, trochlea and medial femoral condyle.

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2011

Lung Resection Procedures

The Society of Thoracic Surgeons (STS) brought forward the lung resection codes voluntarily as part of a major re-organization project to ensure accurate coding and reimbursement for these procedures. In February 2011, CPT Editorial Panel deleted 8 codes, revised 5 codes and created 18 new codes to describe new thoracoscopic procedures and to clarify coding confusion between lung biopsy and lung resection procedures. For the wedge resection procedures, the revisions were based on three tiers; first, the approach, thoracotomy or thoracoscopy; second, the target to remove nodules or infiltrates; and lastly the intent, diagnostic or therapeutic (for nodules only, all infiltrates will be removed for diagnostic purposes).

The coding restructuring and clarification for this family of codes is estimated to result in an overall Medicare work savings of 9 percent compared to the current reporting of these services. The RUC intends to re-examine the volume of these services in three years to confirm the frequency estimates.

The specialty society described the typical patient receiving these services, explaining that the sicker and more complicated patient will typically receive a thoracotomy rather than a thoracoscopy because he/she would most likely not tolerate the intentional collapse of one lung, which is required in order to perform a thoracoscopy. The specialty also noted that removing an infiltrate involves the entire lung, but is less difficult than the removal of a nodule. To remove infiltrates the upper and or lower superficial part of the lung is removed and then examined for infiltrates. Removing a nodule is more difficult, because the nodule is invisible, deeper and harder to resect as the physician must search for a “blip” or protrusion on the lung in order to detect and resect.

32096 Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral

The RUC reviewed the survey results from 84 thoracic surgeons and determined that the survey 25th percentile work RVU of 17.00 and the specialty society recommended time appropriately account for the work and physician time required to perform this procedure. The RUC compared the physician work of 32096 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32096 is more intense and complex to perform and requires more total time to complete than 32662, 436 and 350 minutes total time, respectively. For further support, the RUC referenced similar services, 45160 *Excision of rectal tumor by proctotomy, transsacral or transcoccygeal approach* (work RVU = 16.33 and 342 minutes total time) and 61154 *Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural* (work RVU = 17.07 and 447 minutes total time). **The RUC recommends a work RVU of 17.00 for CPT code 32096.**

32097 Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral

The RUC reviewed the survey results from 83 thoracic surgeons and determined that the survey 25th percentile work RVU of 17.00 and specialty society recommended time appropriately account for the work and physician time required to perform this procedure. The RUC compared the physician work 32097 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32097 is more intense and complex to perform and requires more total time to complete than 32662, 401 and 350 minutes total time, respectively. For further support the RUC referenced similar services, MPC codes 43832 *Gastrostomy, open; with construction of gastric tube (eg, Janeway procedure)* (work RVU = 17.34 and 417 minutes total time) and 44700 *Exclusion of small intestine from pelvis by mesh or other prosthesis, or native tissue (eg, bladder or omentum)* (work RVU = 17.48 and 402 minutes total time). The specialty society indicated that 32097 is slightly more intense and complex than 32096 however, the survey 25th percentile work RVU was 17.00 for both. **The RUC recommends a work RVU of 17.00 for CPT code 32097.**

32098 Thoracotomy, with biopsy(ies) of pleura

The RUC reviewed the survey results from 84 thoracic surgeons and determined that the survey 25th percentile work RVU of 14.99 and specialty society recommended time appropriately accounts for the physician work and time required to perform this procedure. The RUC compared 32098 to key reference service 32651 *Thoracoscopy, surgical; with partial pulmonary decortication* (work RVU = 18.78) and determined that the key reference service requires more physician work and significantly more total time, 341 and 502 minutes, respectively. The RUC then compared 32098 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32098 requires the same work and similar time to perform, 341 and 350 minutes total time, respectively. For further support the RUC referenced similar service, 58260 *Vaginal hysterectomy, for uterus 250 g or less;* (work RVU = 14.15 and 311 minutes total time) and 27216 *Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum)* (work RVU = 15.73 and 393 minutes total time). **The RUC recommends a work RVU of 14.99 for CPT code 32098.**

32100 Thoracotomy; with exploration

The specialty society indicated and the RUC agreed that the patient population and technology has changed for this service since it was last reviewed 10 years ago. Patients for this procedure include those in which perioperative imaging does not delineate if the patient has a resectable central lung cancer. An exploratory thoracotomy is carried out with intraoperative findings that deem the patient unresectable. The RUC reviewed the survey results from 85 thoracic surgeons and determined that a work RVU of 17.00 and specialty society recommended intra time of 90 minutes, total time of 411 minutes, appropriately account for the work and physician time required to perform this procedure. The RUC determined that 32100 is similar to new codes 32096 and 32096, which the RUC is recommending 17.00 for each of these services. The RUC noted that the survey 25th percentile work RVU of 17.50 is similar but could not justify a higher value for 32100. The RUC also compared 32100 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32100 requires more work and time to perform, 411 and 350 minutes total time, respectively. The RUC noted that it did not consider there to be a rank order anomaly between 32100 and 32140 *Thoracotomy; with cyst(s) removal, includes pleural procedure when performed* (work RVU = 16.66) because the physician work required to perform 32100 has increased due to the change in the patient population as indicated above. For further support, the

RUC referenced similar services, 27236 *Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement* (work RVU = 17.61 and 433 minutes total time) and 46710 *Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach* (work RVU = 17.14 and 370 minutes total time). **The RUC recommends a work RVU of 17.00 for CPT code 32100.**

32505 Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial

The RUC reviewed the survey results from 91 thoracic surgeons and determined that the survey 25th percentile work RVU of 18.79 and specialty society recommended time appropriately account for the work and physician time required to perform this procedure. The RUC compared 32505 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32505 is more intense and complex to perform and requires more total time to complete than 32662, 427 and 350 minutes total time, respectively. For further support the RUC referenced similar services, 61751 *Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance* (work RVU = 18.79 and 395 minutes total time) and 44188 *Laparoscopy, surgical, colostomy or skin level cecostomy (separate procedure)* (work RVU = 19.35 and 407 minutes total time). **The RUC recommends a work RVU of 18.79 for CPT code 32505.**

32506 Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 42 thoracic surgeons and agreed with the survey median intra-service time of 25 minutes, and agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated, and the RUC agreed, that the physician work required to perform this service is equivalent to 35697 *Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery* (work RVU= 3.00 and 30 minutes intra-service time). The RUC recommends a direct crosswalk for physician work and the survey median intra-service time of 25 minutes. **The RUC recommends a work RVU of 3.00 for CPT code 32506.**

32507 Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 43 thoracic surgeons and determined that the survey 25th percentile work RVU of 3.78 and specialty society recommended time of 30 minutes intra-service, appropriately account for the work and physician time required to perform this procedure. The RUC compared 32507 to the key reference service 32501 *Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)* (work RVU = 4.68) and agreed with the survey respondents that although 32507 requires 5 more minutes of intra-service time, 30 versus 25 minutes, 32507 is less intense and complex to perform, requiring less technological skill, physical effort and psychological stress. For further support, the RUC referenced similar services, 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)* (work RVU = 4.12 and 30 minutes total time) and 33572 *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)* (work RVU = 4.44 and 30 minutes total time). **The RUC recommends a work RVU of 3.78 for CPT code 32507.**

32601 Thoracoscopy, diagnostic, (separate procedure); lung, pericardial sac, mediastinal or pleural space, without biopsy

The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 60 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated, and the RUC agreed, to crosswalk 32601 to 43257 *Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease* (work RVU = 5.50, intra-service time = 60 and total time = 114). For further support, the RUC also referenced similar service, 52342 *Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 5.85 and intra-service time 60 minutes and total time = 140 minutes). **The RUC recommends a work RVU of 5.50 for CPT code 32601.**

32607 Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral

The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 45 minutes. However, the RUC agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed to crosswalk 32607 to 52301 *Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral* (work RVU = 5.50, intra-service time = 45 and total time = 183). For further support, the RUC also referenced similar service, 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU = 5.35 and intra-service time 45 minutes). **The RUC recommends a work RVU of 5.50 for CPT code 32607.**

32608 Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral

The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 60 minutes. In addition, the RUC agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. The RUC agreed that 32608 requires more work to biopsy the lung nodules compared to biopsy lung infiltrates in code 32607 (RUC recommended work RVU = 5.50). The RUC compared 32608 to key reference service 31600 *Tracheostomy, planned (separate procedure)*; (work RVU = 7.17) and agreed with the survey respondents that the surveyed code is more intense and complex and requires more time to perform than the reference code, 60 and 40 minutes intra-service time, respectively. The RUC compared the incremental differences between the two surveys for 32607 and 32608 and although the work RVUs were overstated (12.50 and 14.00, respectively) the incremental difference was appropriate and maintained rank order between these two services. The RUC recommends a work RVU of 6.84 for code 32608 which maintains rank order among this family of services. For further support, the RUC referenced similar services 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)* (work RVU = 6.99) and 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* (work RVU = 6.72), both which have the same intra-service time of 60 minutes as surveyed code 32608. **The RUC recommends a work RVU of 6.84 for CPT Code 32608.**

32609 Thoracoscopy; with biopsy(ies) of pleura

The RUC reviewed the survey results from 50 thoracic surgeons and agreed with the survey median intra-service time of 45 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated, and the RUC agreed, that the physician work required to perform this service is equivalent

to 15004 *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children* (work RVU 4.58, intra-time = 45 minutes and total time = 150 minutes). Codes and 32609 and 15004 have the same intra-service time of 45 minutes and similar total time, 178 and 150 minutes, respectively. Additionally, the RUC agreed that a work RVU of 4.58 maintains the proper rank order with 32607 and 32608. For further support the RUC referenced code 20902 *Bone graft, any donor area; major or large* (work RVU = 4.58 and intra-service time of 45 minutes). **The RUC recommends a work RVU of 4.58 for CPT code 32609.**

32663 Thoracoscopy, surgical; with lobectomy (single lobe)

The RUC reviewed the survey results from 55 thoracic surgeons and determined that the current work RVU of 24.64, lower than the survey 25th percentile work RVU of 27.23, appropriately accounts for the physician work required to perform this service. The RUC compared 32663 to codes 35351 *Thromboendarterectomy, including patch graft, if performed; iliac* (work RVU = 24.61 and intra-service time = 150 minutes) and 34802 *Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)* (work RVU = 23.79 and intra-service time = 150 minutes) and determined that 32673 requires similar intra-service time, 155 and 150 minutes, respectively, as well as similar intensity and complexity to perform. The RUC recommends maintaining the current work RVU of 24.64 for code 32663. **The RUC recommends a work RVU of 24.64 for CPT code 32663.**

32666 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral

The RUC reviewed the survey results from 55 thoracic surgeons and determined that the survey 25th percentile work RVU of 14.50 and specialty society recommended intra-service time of 75 minutes appropriately account for the work and physician time required to perform this procedure. The RUC compared 32666 to 32662 *Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass* (work RVU = 14.99) and determined that 32666 requires less time to perform, 317 and 350 minutes total time, respectively. For further support the RUC referenced similar service, 21685 *Hyoid myotomy and suspension* (work RVU = 15.26 and 75 minutes intra-service time) and 52601 *Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)* (work RVU = 15.26 and 75 minutes intra-service time). **The RUC recommends a work RVU of 14.50 for CPT code 32666.**

32667 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 44 thoracic surgeons and agreed with the survey median intra-service time of 25 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore the specialty society indicated, and the RUC agreed, that the physician work required to perform this service is equivalent to codes 32506 (RUC recommended work RVU = 3.00 and intra-service time = 25 minutes), 35697 *Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery* (work RVU 3.00 and 30 minutes intra-service time) and 15157 *Tissue cultured epidermal autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof* (work RVU 3.00 and 30 minutes intra-service time). The RUC recommends a direct crosswalk for physician

work to the aforementioned codes and the survey median intra-service time of 25 minutes. **The RUC recommends a work RVU of 3.00 for CPT code 32667.**

32668 Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 44 thoracic surgeons and determined that the survey 25th percentile work RVU of 4.00 and 30 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32668 to code 32507 *Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection* (RUC recommended work RVU = 3.78) and determined that the additional work for 32668 accounts for the increased intensity and complexity to perform the thoracoscopy and maintains the proper rank order among these services. For further support the RUC referenced codes 33572 *Coronary endarterectomy, open, any method, of left anterior descending, circumflex, or right coronary artery performed in conjunction with coronary artery bypass graft procedure, each vessel (List separately in addition to primary procedure)* (work RVU = 4.44) and 61641 *Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular family (List separately in addition to code for primary procedure)* (work RVU = 4.33) both which have the same time of 30 minutes as surveyed code 32668. **The RUC recommends a work RVU of 4.00 for CPT code 32668.**

32669 Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)

The RUC reviewed the survey results from 54 thoracic surgeons and agreed with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed that the physician work and intra-service time of 150 minutes required to perform this service is equivalent to 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)* (work RVU=23.53 and intra-time = 150 minutes). The RUC also agreed that a work RVU of 23.53 maintains the appropriate rank order and incremental difference between the 25th percentile survey results for 32669 and 32663 (26.00 divided by 27.23 work RVUs x 24.64 work RVUs for 32663 = 23.53). For further support, the RUC referenced similar service 58200 *Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)* (work RVU = 23.10 and intra-service time = 150 minutes). **The RUC recommends a work RVU of 23.53 for CPT code 32669.**

32670 Thoracoscopy, surgical; with removal of two lobes (bilobectomy)

The RUC reviewed the survey results from 55 thoracic surgeons and agreed with the survey median intra-service time of 180 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed that the physician work required to perform this service is equivalent to 34451 *Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision* (work RVU = 28.52 and 180 minutes intra-service time). The RUC recommends a direct crosswalk to code 34451 for physician work. **The RUC recommends a work RVU of 28.52 for CPT code 32670.**

32671 Thoracoscopy, surgical; with removal of lung (pneumonectomy)

The RUC reviewed the survey results from 55 thoracic surgeons and determined that the survey 25th percentile work RVU of 31.92 and 180 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32671 to code 32652 *Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis* (work RVU = 29.13) and determined that 32671 is more intense and complex and requires more physician time to perform than 32652, 180 and 160 minutes intra-service time, respectively. For further support the RUC referenced codes 35251 *Repair blood vessel with vein graft; intra-abdominal* (work RVU = 31.91) and 33507 *Repair of anomalous (eg, intramural) aortic origin of coronary artery by unroofing or translocation* (work RVU = 31.40) both which have the same intra-service time as surveyed code 32671, 180 minutes. **The RUC recommends a work RVU of 31.92 for CPT code 32671.**

32672 Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed

The RUC reviewed the survey results from 54 thoracic surgeons and determined that the survey 25th percentile work RVU of 27.00 and 120 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32672 to key reference code 32141 *Thoracotomy, major; with excision-plication of bullae, with or without any pleural procedure* (work RVU = 27.18) and determined that 32672 requires similar physician work and time to perform, 116 and 120 minutes, respectively. For further support, the RUC referenced codes 43880 *Closure of gastrocolic fistula* (work RVU = 27.18) and 43502 *Gastrotomy; with suture repair of pre-existing esophagogastric laceration (eg, Mallory-Weiss)* (work RVU = 25.69) both which have the same intra-service time as surveyed code 32672, 120 minutes. **The RUC recommends a work RVU of 27.00 for CPT code 32672.**

32673 Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral

The RUC reviewed the survey results from 54 thoracic surgeons and determined that the survey 25th percentile work RVU of 21.13 and 150 minutes intra-service time appropriately accounts for the physician work and time required to perform this service. The RUC compared 32673 to codes 35302 *Thromboendarterectomy, including patch graft, if performed; superficial femoral artery* (work RVU = 21.35) and 22905 *Radical resection of tumor (eg, malignant neoplasm), soft tissue of abdominal wall; 5 cm or greater* (work RVU = 21.58) and determined that 32673 requires the same intra-service time of 150 minutes and similar intensity and complexity to perform. **The RUC recommends a work RVU of 21.13 for CPT code 32673.**

32674 Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 44 thoracic surgeons and agreed with the survey median intra-service time of 30 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore, the specialty society indicated and the RUC agreed that the physician work required to perform this service is equivalent to 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (work RVU = 4.12 and 30 minutes intra-service time). The RUC recommends a direct crosswalk to code 34826 for physician work. **The RUC recommends a work RVU of 4.12 for CPT code 32674.**

38746 Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)

The RUC reviewed the survey results from 44 thoracic surgeons and agreed with the survey median intra-service time of 30 minutes. However, the RUC concurred with the specialty society that the survey respondents overestimated the work associated with this service compared to this family of services. Therefore the specialty society indicated and the RUC agreed that the physician work required to perform this service is equivalent to 34826 *Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel* (work RVU = 4.12 and 30 minutes intra-service time). The RUC recommends a direct crosswalk to code 34826 for physician work. **The RUC recommends a work RVU of 4.12 for CPT code 38746.**

Work Neutrality

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

Practice Expense

The RUC recommends the direct practice expense inputs recommended by the specialty society for these procedures performed in the facility setting.

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Surgery Respiratory System Lungs and Pleura</p> <p><u>Pleural cavity or lung biopsy procedures may be accomplished using a percutaneous, thoracoscopic (Video-Assisted Thoroscopic Surgery [VATS]), or thoracotomy approach. They involve the removal of differing amounts of tissue for diagnosis. A biopsy may be performed using different techniques such as incision or wedge. Lung resection procedures include diagnostic and therapeutic procedures, including the removal of blebs, bullae, cysts, and benign or malignant tumors or lesions. These procedures may involve the removal of small portions of the lung or even an entire lung. Additionally, lung resection procedures may require the removal of adjacent structures. Both diagnostic lung biopsies and therapeutic lung resections can be performed utilizing a wedge technique. However, a diagnostic biopsy of a lung nodule using a wedge technique requires only that a tissue sample be obtained without particular attention to resection margins. A therapeutic wedge resection requires attention to margins and complete resection even when the wedge resection is ultimately followed by a more extensive resection. In the case of a wedge resection where intraoperative pathology consultation determines that a more extensive resection is required</u></p>				

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p><u>in the same anatomic location, it becomes classified as a diagnostic wedge resection (32507, 32668). When no more extensive resection is required, the same procedure is a therapeutic wedge resection (32505, 32666).</u></p> <p><u>Pleural or lung biopsies or diagnostic wedge resections should be reported using codes 32096, 32097, 32098, 32400, 32405, 32507, 32607, 32608, 32609 or 32668. The open or thoracoscopic (VATS) therapeutic resection of lung mass or nodules via a wedge resection is reported using codes 32505, 32506, 32666, and 32667. More extensive anatomic lung resection procedures, which can be performed with either thoracotomy or thoracoscopic (VATS) approaches, include: segmentectomy, lobectomy, bilobectomy, and pneumonectomy.</u></p> <p><u>When diagnostic biopsy(ies) of the lung are performed, regardless of the approach (ie open or thoracoscopic (VATS)), or technique (eg, incisional resection, cautery resection, or stapled wedge), and the specimen is sent for intraoperative pathology consultation, and during that same operative session the surgeon uses these results to determine the extent of the necessary surgical resection that includes the anatomical location biopsied, only the most extensive procedure performed (eg, segmentectomy, lobectomy, thoracoscopic (VATS) lobectomy) should be reported.</u></p> <p><u>The therapeutic wedge resection codes (32505, 32506, 32666, or 32667) should not be reported in addition to the more extensive lung procedure (eg, lobectomy) unless the therapeutic wedge resection was performed on a different lobe or on the contralateral lung, whether or not an intraoperative pathology consultation is used to determine the extent of lung resection. When a diagnostic wedge resection is followed by a more extensive procedure in the same anatomical location, report add-on codes 32507 or 32668 with the more extensive procedure(s). When a therapeutic wedge resection (32505, 32506, 32666, or 32667) is performed in a different lobe than the more extensive lung resection (eg lobectomy), report the therapeutic wedge resection with modifier 59</u></p> <p>Incision</p> <p><u>(32000 has been deleted. To report, use 32421)</u></p> <p><u>(32002 has been deleted. To report, use 32422)</u></p> <p><u>(32005 has been deleted. To report, use 32560)</u></p> <p><u>(32019 has been deleted. To report, use 32550)</u></p>				

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
(32020 has been deleted. To report, use 32551)				
(To report wound exploration due to penetrating trauma without thoracotomy, use 20101)				
D 32095		Thoracotomy, limited, for biopsy of lung or pleura <u>(32095 has been deleted. To report, see 32096, 32097, 32098 for thoracotomy with biopsy of the lung or pleura)</u>	090	N/A
●32096	II1	Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral (Do not report 32096 more than once per lung) (Do not report 32096 in conjunction with 32440, 32442, 32445, 32488)	090	17.00
●32097	II2	Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral (Do not report 32097 more than once per lung) (Do not report 32097 in conjunction with 32440, 32442, 32445, 32488)	090	17.00
●32098	II3	Thoracotomy, with biopsy(ies) of pleura	090	14.99
▲32100	II4	Thoracotomy, major ; with exploration and biopsy (Do not report <u>32100</u> in conjunction with <u>19260, 19271, 19272, 32503, 32504</u>)	090	17.00

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
E 32140		with cyst(s) removal, with or without a <u>includes pleural procedure when performed</u>	090	16.66 (No Change)
E 32141		with excision <u>resection</u> -plication of bullae, with or without <u>includes any pleural procedure when performed</u> (For lung volume reduction, use 32491)	090	27.18 (No Change)
<u>Excision/Resection</u>				
E 32400		Biopsy, pleura; percutaneous needle (If imaging guidance is performed, see <u>76942, 77002, 77012, 77021</u>) (For fine needle aspiration, use <u>10021</u> or <u>10022</u>) (For evaluation of fine needle aspirate, see <u>88172, 88173</u>)	000	1.76 (No Change)
D 32402		open (32402 has been deleted. To report open biopsy of pleura, use code 32098)	090	N/A
E 32405		Biopsy, lung or mediastinum, percutaneous needle <u>(For open biopsy of lung see 32096-32097. For open biopsy of mediastinum see 39000 or 39010. For thoracoscopic (VATS) biopsy of lung, pleura, pericardium or mediastinal space structure see 32604, 32606, 32607, 32608, 32609)</u> (For radiological supervision and interpretation, see <u>76942, 77002, 77012, 77021</u>) (For fine needle aspiration, use <u>10022</u>) (For evaluation of fine needle aspirate, see <u>88172, 88173</u>)	000	1.93 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
Removal				
E 32421		Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent (If imaging guidance is performed, see 76942, 77002, 77012) (For total lung lavage, use 32997)	000	1.54 (No Change)
E 32440		Removal of lung, total pneumonectomy;	090	27.28 (No Change)
E 32442		with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)	090	56.47 (No Change)
E 32445		extrapleural (For extrapleural pneumonectomy, with empyemectomy, use 32445 and 32540) (If lung resection is performed with chest wall tumor resection, report the appropriate chest wall tumor resection code 19260-19272, in addition to lung resection code 32440-32445)	090	63.84 (No Change)
E 32480		Removal of lung, other than total pneumonectomy; single lobe (lobectomy)	090	25.82 (No Change)
E 32482		2 lobes (bilobectomy)	090	27.44 (No Change)

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
E 32484		single segment (segmentectomy) (For removal of lung with bronchoplasty, use <u>32501</u>)	090	25.38 (No Change)
E 32486		with circumferential resection of segment of bronchus followed by broncho- bronchial anastomosis (sleeve lobectomy)	090	42.88 (No Change)
E 32488		<u>with</u> all remaining lung following previous removal of a portion of lung (completion pneumonectomy) (For total lobectomy or segmentectomy at lobectomy , with concomitant decortication, use <u>32320</u> and the appropriate removal of lung code)	090	42.99 (No Change)
E 32491		<u>with excision</u> -resection-plication of emphysematous lung(s) (bullous or non- bullous) for lung volume reduction, sternal split or transthoracic approach, <u>includes with or without any pleural procedure, when performed</u>	090	25.24 (No Change)
D 32500		wedge resection, single or multiple (32500 has been deleted. To report open wedge resection of lung see <u>32505</u> , <u>32506</u> , <u>32507</u>)	090	N/A
32504		Resection of apical lung tumor (eg, Pancoast tumor), including chest wall resection, rib(s) resection(s), neurovascular dissection, when performed; with chest wall reconstruction (Do not report <u>32503</u> , <u>32504</u> in conjunction with <u>19260</u> , <u>19271</u> , <u>19272</u> , <u>32100</u> ,	090	36.54 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>32422, 32551)</u> (For performance of lung resection in conjunction with chest wall resection, see <u>19260, 19271, 19272 and 32480-32500, 32503, 32504)</u>)		
●32505	II5	Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial (Do not report 32505, in conjunction with 32440, 32442, 32445, 32488)	090	18.79
● +32506	II6	with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure) (Report 32506 only in conjunction with 32505) (If lung resection is performed with chest wall tumor resection, report the appropriate chest wall tumor resection 19260-19272, in addition to lung resection 32480, 32482, 32484, 32486, 32488, 32505, 32506, 32507)	ZZZ	3.00
●+32507	II7	with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure) (Report 32507 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504)	ZZZ	3.78
<u>Thoracoscopy (VATS-video-assisted thoracic surgery)</u>				
Surgical thoracoscopy (<u>VATS-video-assisted thoracic surgery</u>) always includes diagnostic thoracoscopy.				
For endoscopic procedures, code appropriate endoscopy of each anatomic site examined.				
▲32601	II8	Thoracoscopy, diagnostic, (separate procedure); lung, <u>pericardial sac, mediastinal or pleural space, without biopsy</u>	000	5.50 (No Change)
D 32602		lungs and pleural space, with biopsy	000	N/A

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(32602 has been deleted. To report lung or pleural space biopsy(ies), see 32607, 32608, 32609)		
D 32603		pericardial sac, without biopsy (32603 has been deleted. To report diagnostic thoracoscopy, pericardial sac, without biopsy use 32601)	000	N/A
E 32604		pericardial sac, with biopsy (For open pericardial biopsy, use 39010)	000	8.77 (No Change)
D 32605		mediastinal space, without biopsy (32605 has been deleted. To report diagnostic thoracoscopy within the mediastinal space, use 32601)	000	N/A
E 32606		mediastinal space, with biopsy	000	8.39 (No Change)
●32607	II9	Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral (Do not report 32607 more than once per lung) (Do not report 32607 in conjunction with: 32440, 32442, 32445, 32488, 32671)	000	5.50
●32608	II10	with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral (Do not report 32608 more than once per lung) (Do not report 32608 in conjunction with 32440, 32442, 32445, 32488, 32671)	000	6.84

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●32609	III1	with biopsy(ies) of pleura	000	4.58
E 32655		Thoracoscopy, surgical; with excision resection-plication of bullae, including any pleural procedure <u>when performed</u> (For thoracoscopic (VATS) lung volume reduction surgery, use 32672)	090	16.17 (No Change)
D 32657		with wedge resection of lung, single or multiple (32657 has been deleted. To report thoracoscopic (VATS) wedge resection of lung, see 32666, 32667, 32668)	090	N/A
D 32660		with total pericardiectomy (32660 has been deleted)	090	N/A
▲32663	II16	with lobectomy, total or segmental (eg, single lobe) (For thoracoscopic (VATS) segmentectomy see 32669)	090	24.64 (No Change)
●32666	III2	with therapeutic wedge resection (eg, mass, nodule), initial unilateral (To report bilateral procedure, report 32666 with modifier 50 (Do not report 32666, in conjunction with 32440, 32442, 32445, 32488, 32671)	090	14.50
32665		with esophagomyotomy (Heller type) (For exploratory thoracoscopy, and exploratory thoracoscopy with biopsy, see 32601 -32609)	090	21.53 (No Change)
●+32667	III3	with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)	ZZZ	3.00

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(Report 32667 only in conjunction with 32666) (Do not report 32667 in conjunction with 32440, 32442, 32445, 32488, 32671)		
●+32668	II14	with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure) (Report 32668 in conjunction with 32440, 32442, 33245, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32669, 32663, 32670, 32671)	ZZZ	4.00
●32669	II15	with removal of a single lung segment (segmentectomy)	090	23.53
●32670	II17	with removal of two lobes (bilobectomy)	090	28.52
●32671	II18	with removal of lung (pneumonectomy)	090	31.92
●32672	II19	with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed	090	27.00
●32673	II20	with resection of thymus, unilateral or bilateral (For open thymectomy see 60520, 60521, 60522) (For open excision mediastinal cyst see 39200, for open excision mediastinal tumor use 39220)	090	21.13
●+32674	II21	with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure) (On the right, mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament) (On the left, mediastinal lymph nodes include the aortopulmonary window,	ZZZ	4.12

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		subcarinal, paraesophageal, and inferior pulmonary ligament). (Report 32674 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32505, 32503, 32504, 32666, 32667, 32669, 32663, 32670, 32671) (To report mediastinal and regional lymphadenectomy via thoracotomy, use 38746)		
Cardiovascular System Heart and Pericardium Pericardium (For thoracoscopic (VATS) pericardial procedures see 32601, 32604, 32658, 32659, 32661)				
33025		Creation of pericardial window or partial resection for drainage (For thoracoscopic (VATS) pericardial window, use 32659)	090	13.70 (No Change)
▲33050		Excision Resection of pericardial cyst or tumor (For open pericardial biopsy use 39010) (For thoracoscopic (VATS) resection of pericardial cyst, tumor or mass use 32661)	090	16.97 (No Change)
Hemic and Lymphatic Systems Lymph Nodes and Lymphatic Channels Radical Lymphadenectomy (Radical Resection of Lymph Nodes)				
▲+38746	II22	Thoracic lymphadenectomy <u>by thoracotomy, mediastinal and regional lymphadenectomy, including mediastinal and peritracheal nodes</u> (List separately in	ZZZ	4.12

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		addition to code for primary procedure) <u>(On the right, mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament)</u> <u>(On the left, mediastinal lymph nodes include the aortopulmonary window, subcarinal, paraesophageal, and inferior pulmonary ligament).</u> <u>(Report 38746 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32505, 32503, 32504)</u> <u>(To report mediastinal and regional lymphadenectomy via thoracoscopy (VATS), see 32674)</u>		
Mediastinum and Diaphragm				
Mediastinum				
E 39010		Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy; transthoracic approach, including either transthoracic or median sternotomy <u>(For VATS pericardial biopsy, use 32604)</u>	090	13.19 (No Change)
<u>Excision/Resection</u>				
E 39200		Excision <u>Resection</u> of mediastinal cyst	090	15.09 (No Change)
E 39220		Excision <u>Resection</u> of mediastinal tumor (For substernal thyroidectomy, use 60270) (For thymectomy, use 60520)	090	19.55 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(For thoroscopic (VATS) resection of mediastinal cyst, tumor or mass use 32662)		
Endoscopy				
E 39400		Mediastinoscopy, with <u>includes or without</u> biopsy(ies), when performed	010	8.05 (No Change)

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

CPT Code:32096 Tracking Number III Original Specialty Recommended RVU: **17.00**
Presented Recommended RVU: **17.00**
Global Period: 090 RUC Recommended RVU: **17.00**

CPT Descriptor: Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
(Do not report 32096 more than once per lung)
(Do not report 32096 in conjunction with 32440, 32442, 32445, 32488)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year old female intubated patient has worsening hypoxia. Bilateral diffuse pulmonary infiltrates progressively worsen. Bronchoscopy and bronchoalveolar lavage are non-diagnostic. Microbiologic cultures show usual flora. Patient continues to deteriorate from a respiratory standpoint. Open lung biopsy for diagnosis is necessary.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the reason for lung biopsy is discussed with the physicians caring for the patient. Medical records are reviewed including x-rays identifying the most representative areas of the lungs to biopsy. The patient is seen and examined to rule out concurrent illness and any contraindication to surgery. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then positions the patient in a lateral decubitus position and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The pre-incision surgical pause is completed.

Description of Intra-Service Work: An anterolateral thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and palpation of the parietal pleura, visceral pleura, and lung. Abnormalities of the visceral pleura and lung are noted. It is confirmed that a diffuse infiltrative non-localized process is involving the lung. Both abnormal and normal regions of lung are identified and their relationship to the pulmonary vasculature and bronchial tree assessed to determine that biopsy is feasible. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. The lung is mobilized as needed for

assistance in exposing the areas to be biopsied. Using multiple firings of tissue staplers a wedge resection of the lung is performed removing a portion of lung that contains both abnormal and normal lung tissue. Typically, a second wedge resection from a separate portion of the ipsilateral lung is performed in the same manner. Sterile portions of the resected lung tissue are prepared and sent for appropriate microbiologic testing. The remaining portions of resected lung are typically sent for frozen section pathologic evaluation to ensure that adequate biopsy material has been obtained. If not, additional biopsies are taken. As needed, hemostasis is secured with electrocautery and if necessary the staple lines reinforced with suture. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. The ribs are reapproximated with care to avoid injury to the intercostal neurovascular bundles and the chest wall musculature closed in layers with running suture. The subcutaneous tissue and skin are approximated.

Description of Post-Service Work: A dressing is applied and patient stability ensured. The patient is brought to the recovery room. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. These patients are usually in an ICU and may also be cared for by an intensivist. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage daily. Typically the chest tubes are in for 3-5 days. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32096				
Sample Size:	300	Resp N:	84	Response: 28.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	3.00	5.00	10.00
Survey RVW:		11.00	17.00	21.30	27.05
Pre-Service Evaluation Time:				55.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		35.00	60.00	60.00	90.00
Immediate Post Service-Time:	30.00				
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):	210.00	99231x 1.00	99232x 2.00	99233x 2.00	
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32096	Recommended Physician Work RVU: 17.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	30.00			
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):	210.00	99231x 1.00	99232x 2.00	99233x 2.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32141	090	27.18	RUC Time

CPT Descriptor Thoracotomy, major; with excision-plication of bullae, with or without any pleural 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19318	090	16.03	RUC Time	6,342
<u>CPT Descriptor 1</u> Reduction mammoplasty				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
58150	090	17.31	RUC Time	15,005

CPT Descriptor 2 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32662	090	14.99	RUC Time

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 19.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32096	<u>Key Reference CPT Code:</u> 32141	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	60.00	116.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	210.0	345.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	23.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	436.00	673.00	
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	3.50	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.31
--	------	------

Urgency of medical decision making	3.75	2.63
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.06	3.13
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Physical effort required	3.06	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.81	3.19
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Outcome depends on the skill and judgment of physician	3.69	3.38
--	------	------

Estimated risk of malpractice suit with poor outcome	3.31	3.06
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.38	3.25
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Intra-Service intensity/complexity	3.00	2.94
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Post-Service intensity/complexity	3.56	3.19
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Additional Rationale and Comments

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

A survey was conducted with 84 respondents. 32141 was selected as the Key Reference Service, and was performed 7 times annually by the respondents, compared to 5 times for the surveyed code. The vignette was felt to be typical by 95% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (60 minutes) and immediate post service time (40 minutes) are recommended, as is a length of stay of 6 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 1 time in the office setting, with a 99213 recommended by the expert panel.

We are recommending a work RVU of 17.00 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32141, the expert panel felt that 32096 was of similar intensity, had less intraoperative work and had less postoperative work.

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) 32095, 32100 or 32500

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 Cardiothoracic Surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 1986

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1470 Percentage 74.01 %

Specialty general surgery Frequency 318 Percentage 16.01 %

Specialty other Frequency 199 Percentage 10.02 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,951

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty cardiothoracic surgery Frequency 1444 Percentage 74.01 %

Specialty general surgery Frequency 312 Percentage 15.99 %

Specialty other Frequency 195 Percentage 9.99 %

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

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. 32151

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

CPT Code:32097 Tracking Number II2 Original Specialty Recommended RVU: **17.00**
Presented Recommended RVU: **17.00**
Global Period: 090 RUC Recommended RVU: **17.00**

CPT Descriptor: Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral (Do not report 32097 more than once per lung)
(Do not report 32097 in conjunction with 32440, 32442, 32445, 32488)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year old man with a history of smoking presents with a newly discovered lung nodule. The nodule, location is not amenable to either transthoracic needle aspiration or bronchoscopic biopsy. Lung cancer is suspected. At thoracotomy, multiple other small nodules are found throughout both lungs worrisome for metastatic disease.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the worrisome lung nodule. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The pre-incision surgical pause is completed.

Description of Intra-Service Work: A thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered over the top of the 6th rib. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and if appropriate microbiologic testing. The chest cavity and lung are explored which includes both visual inspection and palpation of the parietal and visceral pleura, diaphragm, mediastinum, and each lung lobe. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. Abnormalities are noted including the presence of multiple small nodules present throughout all of the lung lobes. The small nodules are worrisome for metastatic cancer. The lung is mobilized as needed for assistance in exposing the areas to be biopsied. Using electrocautery a nodule(s) is removed. As necessary hemostasis is secured with electrocautery and if needed the lung parenchymal defect closed with suture. Sterile portions of the resected nodule(s) are prepared and saved for appropriate microbiologic testing. The

remaining portions of the resected lung nodule(s) are sent for frozen section evaluation to obtain a histopathologic diagnosis. Metastatic lung cancer is confirmed. Based upon the number of metastatic nodules observed, the primary tumor is deemed unresectable. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. The ribs are reapproximated with care to avoid injury to the intercostal neurovascular bundles and the chest wall musculature closed in layers with running suture. The subcutaneous tissue and skin are approximated.

Description of Post-Service Work: A dressing is applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage daily. Typically the chest tubes are in for 2-4 days. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32097				
Sample Size:	300	Resp N:	83	Response: 27.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	2.00	5.00	11.00
Survey RVW:		12.00	17.00	20.00	24.69
Pre-Service Evaluation Time:				50.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		40.00	60.00	80.00	90.00
Immediate Post Service-Time:	30.00				
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):	155.00	99231x 1.00	99232x 2.00	99233x 1.00	
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32097	Recommended Physician Work RVU: 17.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		80.00		
Immediate Post Service-Time:	30.00			
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):	155.00	99231x 1.00	99232x 2.00	99233x 1.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32141	090	27.18	RUC Time

CPT Descriptor Thoracotomy, major; with excision-plication of bullae, with or without any pleural 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19318	090	16.03	RUC Time	6,342
<u>CPT Descriptor 1</u> Reduction mammoplasty				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
58150	090	17.31	RUC Time	15,005

CPT Descriptor 2 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32662	090	14.99	RUC Time

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 18 % of respondents: 21.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32097	<u>Key Reference CPT Code:</u> 32141	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	80.00	116.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	345.00	
Median Other Hospital Visit Time	155.0	38.00	
Median Discharge Day Management Time	38.0	39.00	
Median Office Visit Time	23.0	0.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	401.00	673.00	
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	3.44	2.56
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.22
--	------	------

Urgency of medical decision making	3.00	2.61
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.22	2.89
--------------------------	------	------

Physical effort required	3.06	2.94
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.11	3.17
---	------	------

Outcome depends on the skill and judgment of physician	3.39	3.33
--	------	------

Estimated risk of malpractice suit with poor outcome	3.06	3.11
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.28	3.22
----------------------------------	------	------

Intra-Service intensity/complexity	3.06	3.06
------------------------------------	------	------

Post-Service intensity/complexity	3.11	3.22
-----------------------------------	------	------

Additional Rationale and Comments

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

A survey was conducted with 83 respondents. 32141 was selected as the Key Reference Service, and was performed 5 times annually by the respondents, compared to 5 times for the surveyed code. The vignette was felt to be typical by 94% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (80 minutes) and immediate post service time (30 minutes) are recommended, as is a length of stay of 5 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 1 time in the office setting, with a 99213 recommended by the expert panel.

We are recommending a work RVU of 17.00 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32141, the expert panel felt that 32097 had less intraoperative work, less postoperative work and one less office visit.

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) 32095, 32100 and 32500

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1986

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1470 Percentage 74.01 %

Specialty general surgery Frequency 318 Percentage 16.01 %

Specialty other Frequency 199 Percentage 10.02 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,951

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty cardiothoracic surgery Frequency 1444 Percentage 74.01 %

Specialty general surgery Frequency 429 Percentage 21.98 %

Specialty other Frequency 78 Percentage 3.99 %

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

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. 32151

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

CPT Code: 32098 Tracking Number II3 Original Specialty Recommended RVU: **14.99**
Presented Recommended RVU: **14.99**
Global Period: 090 RUC Recommended RVU: **14.99**

CPT Descriptor: Thoracotomy, with biopsy(ies) of pleura

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man presents with chest pain and diffuse pleural thickening.

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 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the abnormally thickened pleura. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The pre-incision surgical pause is completed.

Description of Intra-Service Work: A thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered. It may be necessary to remove a segment of rib for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and if appropriate microbiologic testing. The chest cavity and lung are explored which includes both visual inspection and palpation of the parietal and visceral pleura, diaphragm, mediastinum, and each lung lobe. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. Pleural abnormalities are noted. The lung is retracted as needed for assistance in exposing the areas to be biopsied. The worrisome portions of the pleura are assessed for feasibility of biopsy. Using biopsy forceps or scalpel, pleural biopsies are performed removing at least 1 cm portions of pleura. As necessary hemostasis is secured with electrocautery. Sterile portions of the resected pleura are prepared and saved for appropriate microbiologic testing. The remaining portions of resected pleura are sent for frozen section evaluation to ensure adequate tissue has been obtained, and if possible to obtain histopathologic diagnosis. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. A surgical pause is conducted while an instrument, needle,

and sponge count is completed and confirmed by the surgeon. The ribs are reapproximated with care to avoid injury to the intercostal neurovascular bundles and the chest wall musculature closed in layers with running suture. The subcutaneous tissue and skin are approximated.

Description of Post-Service Work: A dressing is applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage daily. Typically the chest tubes are in for 1-2 days. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32098					
Sample Size:	300	Resp N:	84	Response: 28.0 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	2.00	3.00	6.00	40.00
Survey RVW:		10.00	14.99	18.00	22.85	40.00
Pre-Service Evaluation Time:				50.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				20.00		
Intra-Service Time:		23.00	59.00	60.00	90.00	180.00
Immediate Post Service-Time:	30.00					
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):	115.00	99231x 1.00	99232x 1.00	99233x 1.00		
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32098	Recommended Physician Work RVU: 14.99		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	30.00			
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):	115.00	99231x 1.00	99232x 1.00	99233x 1.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32651	090	18.78	RUC Time

CPT Descriptor Thoracoscopy, surgical; with partial pulmonary decortication**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
63030	090	13.18	RUC Time	36,671

CPT Descriptor 1 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
24430	090	15.25	RUC Time	653

CPT Descriptor 2 Repair of nonunion or malunion, humerus; without graft (eg, compression technique)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32662	090	14.99	RUC Time

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 20 % of respondents: 23.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32098	<u>Key Reference CPT Code:</u> 32651	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	60.00	70.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	115.0	220.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	23.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	341.00	502.00	

Other time if appropriate		
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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	2.53	2.63
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.84	2.74
--	------	------

Urgency of medical decision making	2.47	3.05
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.37	3.16
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Physical effort required	2.47	3.00
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.37	2.68
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Outcome depends on the skill and judgment of physician	2.47	3.05
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Estimated risk of malpractice suit with poor outcome	2.37	2.26
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.68	3.26
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Intra-Service intensity/complexity	2.32	3.00
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Post-Service intensity/complexity	2.37	2.95
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Additional Rationale and Comments

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

A survey was conducted with 84 respondents. 32651 was selected as the Key Reference Service, and was performed 6 times annually by the respondents, compared to 3 times for the surveyed code. The vignette was felt to be typical by 90% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (60 minutes) and immediate post service time (30 minutes) are recommended, as is a length of stay of 4 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 1 time in the office setting, with a 99213 recommended by the expert panel.

We are recommending a work RVU of 14.99 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32651, the expert panel felt 32098 had less intraoperative work, less postoperative care, and 1 less office visit.

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) 32402

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 430

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery	Frequency 353	Percentage 82.09 %
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Specialty general surgery	Frequency 36	Percentage 8.37 %
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Specialty other	Frequency 41	Percentage 9.53 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 323
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 frequency for code 32402 (323) will transfer 100% to the new code.

Specialty cardiothoracic surgery	Frequency 265	Percentage 82.04 %
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Specialty general surgery	Frequency 27	Percentage 8.35 %
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Specialty other	Frequency 31	Percentage 9.59 %
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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

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. 32662

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

CPT Code: 32100 Tracking Number II4 Original Specialty Recommended RVU: **17.50**
Presented Recommended RVU: **17.50**
Global Period: 090 RUC Recommended RVU: **17.00**

CPT Descriptor: Thoracotomy, major; with exploration and biopsy
(Do not report 32100 in conjunction with 19260, 19271, 19272, 32503, 32504)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 65 yo woman with biopsy proven hilar lung cancer and limited lung function who would not tolerate pneumonectomy is explored through a thoracotomy. There is no evidence of pleural or mediastinal nodal metastases. The tumor is found to involve both the superior and inferior pulmonary veins and can only be resected completely if pneumonectomy is performed therefore the patient is unfortunately deemed unresectable and the thoracotomy is closed

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 1%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the abnormally enlarged hilum. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The pre-incision surgical pause is completed.

Description of Intra-Service Work: A thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered over the top of the 6th rib. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and if appropriate microbiologic testing. The chest cavity and lung are explored which includes both visual inspection and palpation of the parietal and visceral pleura, diaphragm, mediastinum, and each lung lobe. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. Abnormalities are noted but no biopsies are performed. Prior to dissecting out the lobar vessels, the main pulmonary artery is dissected out and encircled with vascular tapes in anticipation of performing a difficult lobar dissection. In addition, the appropriate pulmonary vein is dissected out, encircled with vascular tapes. The major fissure is dissected out and the fissure is divided with several applications of the

stapling device. The interlobar pulmonary artery branches are dissected out and encircled with vascular tapes. Unfortunately the tumor is found to involve the main interlobar pulmonary artery and the patient is deemed unresectable given the patient's limited lung function. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. The ribs are reapproximated with care to avoid injury to the intercostal neurovascular bundles and the chest wall musculature closed in layers with running suture. The subcutaneous tissue and skin are approximated.

Description of Post-Service Work: A dressing is applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage daily. Typically the chest tubes are in for 2-4 days. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32100				
Sample Size:	300	Resp N:	85	Response: 28.3 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	1.00	3.00	5.00
Survey RVW:		13.88	17.50	24.00	29.00
Pre-Service Evaluation Time:				60.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		30.00	60.00	90.00	120.00
Immediate Post Service-Time:	30.00				
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):	155.00	99231x 1.00	99232x 2.00	99233x 1.00	
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32100	Recommended Physician Work RVU: 17.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:	30.00			
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):	155.00	99231x 1.00	99232x 2.00	99233x 1.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32141	090	27.18	RUC Time

CPT Descriptor Thoracotomy, major; with excision-plication of bullae, with or without any pleural 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
58150	090	17.31	RUC Time	15,005

CPT Descriptor 1 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
49002	090	17.63	RUC Time	5,836

CPT Descriptor 2 Reopening of recent laparotomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32662	090	14.99	RUC Time

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 20.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32100	<u>Key Reference CPT Code:</u> 32141	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	90.00	116.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	155.0	345.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	23.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	411.00	673.00	
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	3.76	2.35
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.94	2.71
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Urgency of medical decision making	3.53	2.29
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.59	3.06
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Physical effort required	3.47	2.94
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.65	2.94
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Outcome depends on the skill and judgment of physician	4.06	3.12
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Estimated risk of malpractice suit with poor outcome	3.00	2.59
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INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.82	3.00
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Intra-Service intensity/complexity	3.76	2.94
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Post-Service intensity/complexity	3.29	3.06
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Additional Rationale and Comments

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

A survey was conducted with 85 respondents. 32141 was selected as the Key Reference Service, and was performed 6 times annually by the respondents, compared to 3 times for the surveyed code. The vignette was felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (90 minutes) and immediate post service time (_30 minutes) are recommended, as is a length of stay of 5_ days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 1 times in the office setting, with a 99213 recommended by the expert panel.

We are recommending a work RVU of 17.00 for this code. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32141, the expert panel felt that 32100 had less intraoperative work but was of similar intensity, less postoperative work and less office visits.

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) 32100

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 637

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery	Frequency 510	Percentage 80.06 %
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Specialty general surgery	Frequency 72	Percentage 11.30 %
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Specialty other	Frequency 55	Percentage 8.63 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 479
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that of the 2009 frequency for code 32100 will shift to new codes 32096 and 32097 and that 25% of the procedures will still be reported under code 32100

Specialty cardiothoracic surgery	Frequency 383	Percentage 79.95 %
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Specialty general surgery	Frequency 54	Percentage 11.27 %
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Specialty other	Frequency 41	Percentage 8.55 %
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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

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. 32660

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

CPT Code: 32505 Tracking Number IIS Original Specialty Recommended RVU: **18.79**
Presented Recommended RVU: **18.79**
Global Period: 090 RUC Recommended RVU: **18.79**

CPT Descriptor: Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial

(Do not report 32505, in conjunction with 32440, 32442, 32445, 32488)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male nonsmoker with a history of resected colon cancer and adjuvant chemotherapy is found to have a growing right pulmonary nodule. There is no evidence of locally recurrent colon cancer or intra-abdominal metastatic disease. There is no mediastinal lymphadenopathy or evidence of other pulmonary nodules. Pulmonary function is normal. Metastatic colon cancer to the right lung is suspected.

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 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the abnormal lung nodule. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The pre-incision surgical pause is completed.

Description of Intra-Service Work: A thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered over the top of the 6th rib. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and if appropriate microbiologic testing.

The chest cavity and lung are explored which includes both visual inspection and palpation of the parietal and visceral pleura, diaphragm, mediastinum, and each lung lobe. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. Abnormalities are noted. The worrisome lung nodule is located and its relationship to the pulmonary vasculature and bronchial tree assessed to determine if resection is feasible. The lung is mobilized as necessary for assistance in exposing the nodule. Using multiple firings of tissue staplers a wedge resection of the nodule is performed

removing the nodule with at least a 1- to 2 cm free margin of normal lung parenchyma. As necessary hemostasis is secured with electrocautery and if needed the staple lines reinforced with suture. Sterile portions of the resected nodule are prepared and sent for if appropriate microbiologic testing. The remaining portions of resected lung are sent for frozen section evaluation to obtain a histopathologic diagnosis and confirm a clean margin. If cancer is confirmed, then thoracic lymphadenectomy may be indicated. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. The ribs are reapproximated with care to avoid injury to the intercostal neurovascular bundles and the chest wall musculature closed in layers with running suture. The subcutaneous tissue and skin are approximated.

Description of Post-Service Work: A dressing is applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery.. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage daily. Typically the chest tubes are in for 2-4 days. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32505				
Sample Size:	300	Resp N:	91	Response: 30.3 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	3.00	10.00	19.00
Survey RVW:		12.00	18.79	23.18	27.00
Pre-Service Evaluation Time:				55.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		42.00	68.00	90.00	90.00
Immediate Post Service-Time:	30.00				
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):	155.00	99231x 1.00	99232x 2.00	99233x 1.00	
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00	14x 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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32505	Recommended Physician Work RVU: 18.79		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:	30.00			
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):	155.00	99231x 1.00	99232x 2.00	99233x 1.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32141	090	27.18	RUC Time

CPT Descriptor Thoracotomy, major; with excision-plication of bullae, with or without any pleural 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
50220	090	18.68	RUC Time	1,706

CPT Descriptor 1 Nephrectomy, including partial ureterectomy, any open approach including rib resection;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
38100	090	19.55	RUC Time	2,817

CPT Descriptor 2 Splenectomy; total (separate procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32662	090	14.99	RUC Time

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 30.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32505	<u>Key Reference CPT Code:</u> 32141	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	90.00	116.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	155.0	345.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	427.00	673.00	

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	3.57	2.96
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.68	3.54
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Urgency of medical decision making	2.96	2.82
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.29	3.18
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Physical effort required	3.36	3.21
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.36
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Outcome depends on the skill and judgment of physician	3.43	3.68
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Estimated risk of malpractice suit with poor outcome	3.50	3.50
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INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.39	3.54
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Intra-Service intensity/complexity	3.14	3.32
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Post-Service intensity/complexity	3.25	3.61
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Additional Rationale and Comments

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

A survey was conducted with 91 respondents. 32662 was selected as the Key Reference Service, and was performed 6 times annually by the respondents, compared to 10 times for the surveyed code. The vignette was felt to be typical by 92% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (90 minutes) and immediate post service time (30 minutes) are recommended, as it a length of stay of 5 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

We are recommending a work RVU of 18.79 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32141, the expert panel felt 32505 had more complex intraoperative decision making associated with it with regards to sparing the appropriate amount of lung and corresponding bronchovascular structures when doing the wedge resection and simultaneously ensuring negative margins to properly remove the cancer. The postoperative care is more intense due to management of air leaks from the staple lines. Two postoperative visits are required to adequately manage the incisional pain, remove sutures, review the chest radiograph, and discuss the pathology report with the patient and communicate with the referring oncologist for possible additional adjuvant therapy and follow-up.

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) 32500

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 8630

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 7218 Percentage 83.63 %

Specialty general surgery Frequency 869 Percentage 10.06 %

Specialty other Frequency 543 Percentage 6.29 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 4,375

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. For the therapeutic wedge resection procedures, it is estimated that the current frequency from 32500 (6489) will shift to the new codes 32055 and +32507.

Specialty cardiothoracic surgery Frequency 3658 Percentage 83.61 %

Specialty general surgery Frequency 438 Percentage 10.01 %

Specialty other Frequency 279 Percentage 6.37 %

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

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. 32651

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

CPT Code:32506 Tracking Number II6 Original Specialty Recommended RVU: **3.50**
Presented Recommended RVU: **3.50**
Global Period: ZZZ RUC Recommended RVU: **3.00**

CPT Descriptor: Thoracotomy; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)
(Report 32506 only in conjunction with 32505)
(If lung resection is performed with chest wall tumor resection, report the appropriate chest wall tumor resection 19260-19272, in addition to lung resection 32480, 32482, 32484, 32486, 32488, 32505, 32506, 32507)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male nonsmoker with a history of resected colon cancer and adjuvant chemotherapy is found to have a growing right upper lobe pulmonary nodule. There is no evidence of locally recurrent colon cancer or intra-abdominal metastatic disease. There is no mediastinal lymphadenopathy but an additional pulmonary nodule within the lower lobe is found. Pulmonary function is normal. Metastatic colon cancer to the right lung is suspected. The patient has a right thoracotomy with wedge resection of the right upper lobe nodule (separately reported). Frozen section pathology reveals grade 2 adenocarcinoma consistent with a colon primary. A separate wedge resection of the right lower lobe nodule is performed also showing metastatic colon cancer.

For this procedure consider only the work of the additional wedge resection in the separate lobe. This is an add-on service.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: There is no additional pre-service work

Description of Intra-Service Work: If there is more than one lung nodule present, then after the first wedge resection is performed and histopathologic diagnosis confirmed, wedge resection of the additional nodule(s) may be indicated. This entails performing the additional necessary wedge resection(s) in the same fashion as the initial wedge resection utilizing multiple firings of the tissue staplers ensuring clean margins. Some nodules may require electrocautery resection with suture closure of the lung parenchymal defect. Each of the resected nodules should be sent for histopathologic examination. The anesthetist is asked to inflate the operated lung and all resection sites are assessed for both hemostasis and air leakage. Additional suture reinforcement of staple (suture) lines is done as needed.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32506				
Sample Size:	300	Resp N:	42	Response: 14.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	5.00	10.00	20.00
Survey RVW:		1.25	3.50	4.50	7.00
Pre-Service Evaluation Time:				5.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		10.00	15.00	25.00	40.00
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:	32506	Recommended Physician Work RVU: 3.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		25.00		
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32501	ZZZ	4.68	RUC Time

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
63048	ZZZ	3.47	RUC Time	120,569

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22525	ZZZ	4.47	RUC Time	13,121

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
44213	ZZZ	3.50	RUC Time

CPT Descriptor Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to 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: 8 % of respondents: 19.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32506	<u>Key Reference CPT Code:</u> 32501	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	25.00	25.00	
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	25.00	25.00
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	3.25	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.25
Urgency of medical decision making	3.25	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	3.13	3.38
Physical effort required	3.38	3.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.88	3.63
Outcome depends on the skill and judgment of physician	2.75	3.50
Estimated risk of malpractice suit with poor outcome	2.75	2.88

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	3.50
Intra-Service intensity/complexity	3.38	3.63
Post-Service intensity/complexity	3.00	3.13

Additional Rationale and Comments

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

A survey was conducted with 42 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 10 times for the surveyed code. The vignette was felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time was 25 minutes.

We are recommending a work RVU of 3.00 for this code. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32501, the expert panel felt 32506 took about the same amount of time and had less intensity.

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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32500

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 863

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 705 Percentage 81.69 %

Specialty general surgery Frequency 85 Percentage 9.84 %

Specialty other Frequency 53 Percentage 6.14 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 438
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty cardiothoracic surgery Frequency 368 Percentage 84.01 %

Specialty general surgery Frequency 44 Percentage 10.04 %

Specialty other Frequency 16 Percentage 3.65 %

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

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. 33517

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

CPT Code:32507 Tracking Number II7 Original Specialty Recommended RVU: **3.78**
Presented Recommended RVU: **3.78**
Global Period: ZZZ RUC Recommended RVU: **3.78**

CPT Descriptor: Thoracotomy; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)
(Report 32507 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old male smoker is found to have a growing left spiculated pulmonary nodule now measuring 3 cm in size. There is no evidence of metastatic disease. Pulmonary function is normal. Resection is indicated. The patient undergoes a diagnostic wedge resection to be followed by an appropriate more extensive resection (reported separately) based upon intraoperative pathology findings. This service represents only the additional services of the diagnostic wedge resection in a patient who goes on to have a more extensive lung resection procedure based upon the intraoperative pathology findings.

For this procedure consider only the work of the diagnostic wedge resection that is sent for intraoperative pathology. This is an add-on service

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: There is no additional pre-service work

Description of Intra-Service Work: A thoracotomy incision is made, and utilizing electrocautery the chest is carefully entered over the top of the 6th rib. It may be necessary to remove a segment of rib to prevent trauma when spreading of the ribs for exposure. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and if appropriate microbiologic testing. The chest cavity and lung are explored which includes both visual inspection and palpation of the parietal and visceral pleura, diaphragm, mediastinum, and each lung lobe. Abnormalities are noted. The worrisome lung nodule is located and its relationship to the pulmonary vasculature and bronchial tree assessed to determine that biopsy is feasible. If possible, single lung ventilation of the contralateral lung is instituted to facilitate exposure. The lung is mobilized as needed for assistance in exposing the nodule. Using multiple firings of tissue staplers a wedge resection of the nodule is performed removing the nodule with at least a 1- to 2 cm margin of normal lung parenchyma. As necessary, hemostasis is secured with electrocautery and if needed the staple lines reinforced with suture.

Sterile portions of the resected nodule are saved for appropriate microbiologic testing if indicated. The remaining portions of resected lung are sent for frozen section evaluation to obtain a histopathologic diagnosis. If lung cancer is confirmed, then anatomic resection (eg, segmentectomy, lobectomy, pneumonectomy) (separately reported) may be indicated.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32507				
Sample Size:	300	Resp N:	43	Response: 14.3 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	4.00	10.00	20.00
Survey RVW:		1.25	3.78	4.72	8.00
Pre-Service Evaluation Time:				10.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	20.00	30.00	45.00
Immediate Post Service-Time:		<u>0.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:	32507	Recommended Physician Work RVU: 3.78		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		30.00		
Immediate Post Service-Time:		<u>0.00</u>		
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32501	ZZZ	4.68	RUC Time

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
63048	ZZZ	3.47	RUC Time	120,569

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22525	ZZZ	4.47	RUC Time	13,121

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
44213	ZZZ	3.50	RUC Time

CPT Descriptor Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to 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: 8 % of respondents: 18.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32507	<u>Key Reference CPT Code:</u> 32501	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	25.00	
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	25.00
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	3.25	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.25
Urgency of medical decision making	3.25	3.38

Technical Skill/Physical Effort (Mean)

Technical skill required	3.13	3.38
Physical effort required	3.25	3.38

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.88	3.63
Outcome depends on the skill and judgment of physician	3.13	3.63
Estimated risk of malpractice suit with poor outcome	2.75	3.00

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.25
Intra-Service intensity/complexity	3.25	3.63
Post-Service intensity/complexity	3.00	3.13

Additional Rationale and Comments

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

A survey was conducted with 43 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 10 times for the surveyed code. The vignette was felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time was 30 minutes.

We are recommending a work RVU of 3.78 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32501, the expert panel felt 32507 took slightly more time but was less intense.

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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) This service was generally not previously reported. It is estimated that if it was reported it was reported 15% of the time with code 32500 and 11% of the time with code 32095.

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1686

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery	Frequency 1411	Percentage 83.68 %
Specialty general surgery	Frequency 170	Percentage 10.08 %
Specialty other	Frequency 106	Percentage 6.28 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,200
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty cardiothoracic surgery	Frequency 1004	Percentage 83.66 %
Specialty general surgery	Frequency 120	Percentage 10.00 %
Specialty other	Frequency 76	Percentage 6.33 %

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

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. 33517

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

CPT Code:32601 Tracking Number II8 Original Specialty Recommended RVU: **5.50**
Presented Recommended RVU: **5.50**
Global Period: 000 RUC Recommended RVU: **5.50**

CPT Descriptor: Thoracoscopy, diagnostic, (separate procedure); lung, pericardial sac, mediastinal or pleural space, without biopsy

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old man presents with a 4-week history of progressive shortness of breath. Chest x-ray shows blunting of the costophrenic angles on the right. Thoracentesis is nondiagnostic.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: On the day of surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar placement is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 to 2) if necessary are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and each lung lobe. No abnormalities of the visceral and parietal

pleura and lung are noted and no biopsies are performed. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders for the operative day written. On the operative day, the procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays from the operative day are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32601				
Sample Size:	300	Resp N:	50	Response: 16.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		2.00	10.00	15.00	25.00
Survey RVW:		5.25	12.00	14.00	16.38
Pre-Service Evaluation Time:				28.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		10.00	45.00	60.00	71.00
Immediate Post Service-Time:	30.00				
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 1.00	99233x 1.00	
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
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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32601	Recommended Physician Work RVU: 5.50		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		28.00	40.00	-12.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	30.00			
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):	40.00	99231x 0.00	99232x 1.00	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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31600	000	7.17	RUC Time

CPT Descriptor Tracheostomy, planned (separate 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52342	000	5.85	RUC Time	291

CPT Descriptor 1 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52276	000	4.99	RUC Time	11,919

CPT Descriptor 2 Cystourethroscopy with direct vision internal urethrotomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37182	000	16.97	RUC Time

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 13 % of respondents: 26.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32601	<u>Key Reference CPT Code:</u> 31600	<u>Source of Time</u> RUC Time
Median Pre-Service Time	63.00	50.00	
Median Intra-Service Time	60.00	40.00	
Median Immediate Post-service Time	30.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	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	193.00	156.00
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	3.62	2.08
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.77	2.46
--	------	------

Urgency of medical decision making	3.23	2.77
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.31	2.92
--------------------------	------	------

Physical effort required	2.54	2.46
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.15	2.77
---	------	------

Outcome depends on the skill and judgment of physician	3.23	2.69
--	------	------

Estimated risk of malpractice suit with poor outcome	2.77	2.85
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.46	2.38
----------------------------------	------	------

Intra-Service intensity/complexity	3.62	2.54
------------------------------------	------	------

Post-Service intensity/complexity	3.15	2.38
-----------------------------------	------	------

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.*

A survey was conducted and composed of 50 respondents. Code 31600 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 15 times for the surveyed code. Despite the 0 performance rate of the reference code, all thoracic surgeons are completely familiar with this procedure and have performed it many times in their careers. In 2009, the Key Reference Service was

performed 3,452 times by thoracic surgeons. The vignette was felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient.

Survey respondents indicated that two hospital visits were typically performed, which is not consistent with the global period. The expert panel recommended a single 99232 to represent the typical evaluation and management service performed on the evening of surgery within the global period. The panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: Reduced to 28 min. based on survey response

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning.

Scrub, dress, wait: No change.

The survey median intraservice time of 60 minutes and immediate post service time of 30 minutes are recommended.

We are recommending a work RVU of 5.50 for this code, which is the frequency weighted average of codes 32601, 32603, and 32605 which are being collapsed into this code. This value is below the 25th percentile of the survey, is selected solely to preserve budget neutrality and rank order in the proposal and is not representative of the physician work actually performed. The resulting IWP/UT is 0.037, which is consistent with the inaccuracy of this recommendation, particularly compared to the reference code IWP/UT of 0.114.

We recommend that this code be identified in the RUC database as valid for physician time and visit pattern only

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) 32601, 32603, 32605

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 3238

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 2619 Percentage 80.88 %

Specialty general surgery Frequency 369 Percentage 11.39 %

Specialty other Frequency 251 Percentage 7.75 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,435

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization data for codes 32601 (2362), 32603 (27), and 32605 (46) was combined to get the total estimated frequency of 2435 procedruers that will be reproted with the code 32601 for Medicare.

Specialty cardiothoracic surgery Frequency 1969 Percentage 80.86 %

Specialty general surgery Frequency 277 Percentage 11.37 %

Specialty other Frequency 188 Percentage 7.72 %

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 32601

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:32607 Tracking Number II9 Original Specialty Recommended RVU: **5.47**
 Presented Recommended RVU: **5.47**
 Global Period: 000 RUC Recommended RVU: **5.50**

CPT Descriptor: Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
 (Do not report 32607 more than once per lung)
 (Do not report 32607 in conjunction with, 32440, 32442, 32445, 32488, 32671)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 56-year-old male with worsening dyspnea and progressive bilateral diffuse infiltrates on CT scan. Transbronchial biopsies were nondiagnostic.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: On the day of surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the most representative areas of the lungs to biopsy. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc..) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 to 2) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural

fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum and each of the lung lobes. Abnormalities of the lung are noted. A diffuse infiltrative non-localized process involving the lung is seen. Both abnormal and normal regions of lung are identified and their relationship to the pulmonary vasculature and bronchial tree assessed to determine that biopsy is feasible. Using multiple firings of the endoscopic tissue staplers, at least 2 wedge resections of the lung are performed removing portions of both abnormal and normal lung. Each specimen prior to removal from the chest is placed in a sterile bag to avoid trocar site contamination. As necessary hemostasis is secured with electrocautery and if needed the staple lines reinforced with suture. Sterile portions of the resected lung are prepared and sent for appropriate microbiologic testing. The remaining portions of resected lung are sent for frozen section pathologic evaluation to ensure that adequate biopsy material has been obtained. If not, additional biopsies are taken. The anesthetist is asked to inflate the operated lung and it is assessed for both hemostasis and air leakage. The lung is again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders for the operative day written. On the operative day, the procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays from the operative day are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32607				
Sample Size:	300	Resp N:	50	Response: 16.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	4.00	6.00	12.00
Survey RVW:		5.25	9.00	12.50	15.00
Pre-Service Evaluation Time:				28.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		10.00	30.00	45.00	60.00
Immediate Post Service-Time:	30.00				
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 1.00	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
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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32607	Recommended Physician Work RVU: 5.50		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		28.00	40.00	-12.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		45.00		
Immediate Post Service-Time:	30.00			
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):	40.00	99231x 0.00	99232x 1.00	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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31600	000	7.17	RUC Time

CPT Descriptor Tracheostomy, planned (separate 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
45380	000	4.43	RUC Time	799,816
<u>CPT Descriptor 1</u> Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52342	000	5.85	RUC Time	291

CPT Descriptor 2 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37182	000	16.97	RUC Time

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 20 % of respondents: 40.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32607	<u>Key Reference CPT Code:</u> 31600	<u>Source of Time</u> RUC Time
Median Pre-Service Time	63.00	50.00	
Median Intra-Service Time	45.00	40.00	
Median Immediate Post-service Time	30.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	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	178.00	156.00
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	3.35	1.95
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.30	2.30
--	------	------

Urgency of medical decision making	2.95	2.70
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.80	2.70
--------------------------	------	------

Physical effort required	2.70	2.45
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.90	2.75
---	------	------

Outcome depends on the skill and judgment of physician	3.20	2.65
--	------	------

Estimated risk of malpractice suit with poor outcome	2.75	2.70
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.25	2.30
----------------------------------	------	------

Intra-Service intensity/complexity	2.90	2.45
------------------------------------	------	------

Post-Service intensity/complexity	2.95	2.25
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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.*

A survey was conducted with 51 respondents. Code 31600 was selected as the Key Reference Service, and was performed 3 times annually by the respondents, compared to 6 times for the surveyed code. The vignette was felt to be typical by 98% of the respondents, and the procedure was typically performed as an inpatient.

Survey respondents indicated that two hospital visits were typically performed, which is not consistent with the global period. The expert panel recommended a single 99232 to represent the typical evaluation and management service performed on the evening of surgery within the global period. The panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: Reduced to 28 min. based on survey response

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning.

Scrub, dress, wait: No change.

The survey median intraservice time of 45 minutes and the survey median immediate post service time of 30 minutes are recommended.

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) 32602 and 32657

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2909

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1559 Percentage 76.83 %

Specialty general surgery Frequency 285 Percentage 14.04 %

Specialty other Frequency 185 Percentage 9.11 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,183
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 9% of 32657 and 40% of 32602 current 2009 Medicare utilization

Specialty cardiothoracic surgery Frequency 1677 Percentage 76.82 %

Specialty general surgery Frequency 306 Percentage 14.01 %

Specialty other Frequency 200 Percentage 9.16 %

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

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. 32601

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

CPT Code:32608 Tracking Number II10

Original Specialty Recommended RVU: **6.84**Presented Recommended RVU: **6.84**

Global Period: 000

RUC Recommended RVU: **6.84**

CPT Descriptor: Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral

(Do not report 32608 more than once per lung)

(Do not report 32608 in conjunction with 32440, 32442, 32445, 32488, 32671)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 65-year-old male smoker presents with a growing pulmonary nodule, which is suspicious for lung cancer. Multiple other small nodules close to the surface within the same lung are seen on CT.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: On the day of surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the worrisome lung nodules. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 to 2) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary

are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum and each of the lung lobes. Abnormalities are noted. Nodularity of the visceral pleura and lung are noted. Biopsy of one of the lung nodules is accomplished by one of several techniques; core cutting needle biopsy, electrocautery excision, ultrasonic scalpel excision or stapled biopsy. Prior to removal from the chest cavity, the biopsied lung tissue is placed in a sterile bag in order to prevent trocar site contamination. As necessary hemostasis is secured with electrocautery and if needed the biopsy site is reinforced with sutures. If appropriate, sterile portions of the biopsied nodule are prepared and sent for appropriate microbiologic testing. The remaining portions of biopsied nodule are sent for frozen section evaluation to obtain a histopathologic diagnosis. Metastatic lung cancer is confirmed. Because of the extent of metastatic disease, the primary tumor is not resected. After completion of all necessary biopsies(s), the anesthetist is asked to inflate the operated lung and all biopsy sites are assessed for both hemostasis and air leakage. The lung is again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders for the operative day written. On the operative day, the procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays from the operative day are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32608				
Sample Size:	300	Resp N:	50	Response: 16.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		2.00	7.00	12.00	20.00
Survey RVW:		5.25	12.00	14.00	16.00
Pre-Service Evaluation Time:				30.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		15.00	45.00	60.00	60.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32608	Recommended Physician Work RVU: 6.84		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		30.00	40.00	-10.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>40.00</u>	99231x 0.00	99232x 1.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31600	000	7.17	RUC Time

CPT Descriptor Tracheostomy, planned (separate 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52342	000	5.85	RUC Time	291
<u>CPT Descriptor 1</u> Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34812	000	6.74	RUC Time	33,522

CPT Descriptor 2 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37182	000	16.97	RUC Time

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 30.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32608	<u>Key Reference CPT Code:</u> 31600	<u>Source of Time</u> RUC Time
Median Pre-Service Time	65.00	50.00	
Median Intra-Service Time	60.00	40.00	
Median Immediate Post-service Time	30.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	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	195.00	156.00
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	3.47	2.07
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	2.40
Urgency of medical decision making	3.27	2.73

Technical Skill/Physical Effort (Mean)

Technical skill required	3.13	2.67
Physical effort required	2.80	2.40

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.13	2.73
Outcome depends on the skill and judgment of physician	3.27	2.67
Estimated risk of malpractice suit with poor outcome	2.73	2.73

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.53	2.40
Intra-Service intensity/complexity	3.27	2.53
Post-Service intensity/complexity	3.20	2.27

Additional Rationale and Comments

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

A survey was conducted with 50 respondents. Code 31600 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 12 times for the surveyed code. Despite the 0

performance rate of the reference code, all thoracic surgeons are completely familiar with this procedure and have performed it many times in their careers. In 2009, the Key Reference Service was performed 3,452 times by thoracic surgeons. The vignette was felt to be typical by 98% of the respondents, and the procedure was typically performed as an inpatient.

Survey respondents indicated that two hospital visits were typically performed, which is not consistent with the global period. The expert panel recommended a single 99232 to represent the typical evaluation and management service performed on the evening of surgery within the global period. The panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: Reduced to 30 min. based on survey response

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 60 minutes which is the median time and the median immediate post service time of 30 minutes are recommended.

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) 32602 and 32657

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2909

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1558 Percentage 53.55 %

Specialty general surgery Frequency 285 Percentage 9.79 %

Specialty other Frequency 185 Percentage 6.35 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,183

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 9% of 32657 and 40% of 32602 current 2009 Medicare utilization

Specialty cardiothoracic surgery Frequency 1677 Percentage 76.82 %

Specialty general surgery Frequency 306 Percentage 14.01 %

Specialty other Frequency 200 Percentage 9.16 %

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

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. 32605

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

CPT Code:32609 Tracking Number III1

Original Specialty Recommended RVU: **4.10**

Global Period: 000

Presented Recommended RVU: **4.58**RUC Recommended RVU: **4.58**

CPT Descriptor: Thoracoscopy; with biopsy(ies) of pleura

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 68-year-old male pipe fitter presents with progressive dyspnea. A left pleural effusion is found along with generalized parietal pleural thickening. Pleural fluid cytology is nondiagnostic. Pleural biopsy is needed to establish diagnosis.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: On the day of surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the pleural abnormalities. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 to 2) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes

both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum and each of the lung lobes. Abnormalities of the visceral and parietal pleura are noted, and the worrisome portions of the pleura are identified and assessed for feasibility of biopsy. Using biopsy forceps or other thoracoscopic instrumentation pleural biopsies are performed removing at least 1- to 2 cm portions of pleura. Each specimen prior to removal from the chest is placed in a sterile bag to avoid trocar site contamination. If appropriate, sterile portions of the resected pleura are prepared and sent for appropriate microbiologic testing. The remaining portions of resected pleura are sent for frozen section evaluation to ensure adequate tissue has been obtained, and if possible to obtain histopathologic diagnosis. After completion of all necessary biopsy(s)resection(s), the anesthetist is asked to inflate the operated lung assessing it for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders for the operative day written. On the operative day, the procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays from the operative day are reviewed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32609				
Sample Size:	300	Resp N:	50	Response: 16.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		2.00	7.00	12.00	20.00
Survey RVW:		4.95	9.00	12.00	14.94
Pre-Service Evaluation Time:				28.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		10.00	30.00	45.00	60.00
Immediate Post Service-Time:	30.00				
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 1.00	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
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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32609	Recommended Physician Work RVU: 4.58		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		28.00	40.00	-12.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		45.00		
Immediate Post Service-Time:	30.00			
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):	40.00	99231x 0.00	99232x 1.00	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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
31600	000	7.17	RUC Time

CPT Descriptor Tracheostomy, planned (separate 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19103	000	3.69	RUC Time	107,851

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

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
45380	000	4.43	RUC Time	799,816

CPT Descriptor 2 Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37182	000	16.97	RUC Time

CPT Descriptor Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 19 % of respondents: 38.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32609	<u>Key Reference CPT Code:</u> 31600	<u>Source of Time</u> RUC Time
Median Pre-Service Time	63.00	50.00	
Median Intra-Service Time	45.00	40.00	
Median Immediate Post-service Time	30.00	66.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	40.0	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	178.00	156.00
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	3.47	2.07
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.60	2.40
--	------	------

Urgency of medical decision making	3.27	2.73
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.13	2.67
--------------------------	------	------

Physical effort required	2.80	2.40
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.13	2.73
---	------	------

Outcome depends on the skill and judgment of physician	3.27	2.67
--	------	------

Estimated risk of malpractice suit with poor outcome	2.73	2.73
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.53	2.40
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Intra-Service intensity/complexity	3.27	2.53
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Post-Service intensity/complexity	3.20	2.27
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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.*

A survey was conducted with 51 respondents. Code 31600 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 12 times for the surveyed code. Despite the 0 performance rate of the reference code, all thoracic surgeons are completely familiar with this procedure and have performed it many times in their careers. In 2009, the Key Reference Service was performed 3,452 times

by thoracic surgeons. The vignette was felt to be typical by 98% of the respondents, and the procedure was typically performed as an inpatient.

Survey respondents indicated that two hospital visits were typically performed, which is not consistent with the global period. The expert panel recommended a single 99232 to represent the typical evaluation and management service performed on the evening of surgery within the global period. The panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: Reduced to 28 min. based on survey response

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 45 minutes which is the median time and the median immediate post service time of 30 minutes are recommended.

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) 32602

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 403

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery	Frequency 306	Percentage 75.93 %
Specialty general surgery	Frequency 56	Percentage 13.89 %
Specialty other	Frequency 41	Percentage 10.17 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 302
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization data for the current code 32602 is 3,390. Of this, it is estimated that 9% will be reported with 32609

Specialty cardiothoracic surgery	Frequency 232	Percentage 76.82 %
Specialty general surgery	Frequency 43	Percentage 14.23 %
Specialty other	Frequency 27	Percentage 8.94 %

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

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. 33572

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

CPT Code:32663 Tracking Number III16

Original Specialty Recommended RVU: **24.64**Presented Recommended RVU: **24.64**

Global Period: 090

RUC Recommended RVU: **24.64**

CPT Descriptor: Thoracoscopy, surgical; with lobectomy, total or segmental (eg, single lobe)
(For thoracoscopic (VATS) segmentectomy see 3266X4)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63 year old former smoker presents with a 2 cm adenocarcinoma located peripherally in the left lower lobe. The staging workup shows no evidence of metastatic disease. The patients pulmonary function is such he would tolerate lobectomy.

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 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the lung cancer. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc..) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (3 or 4) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion as is the larger accessory incision. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the

lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The lung cancer present in the lower lobe is identified. The lung is retracted superiorly to expose the diaphragmatic surface. The inferior pulmonary ligament is divided with electrocautery, and the mediastinal pleura dissected away from the inferior pulmonary vein anteriorly and posteriorly. A right angle clamp is used to carefully dissect around the inferior pulmonary vein away from the superior pulmonary vein to the upper lobe., The endoscopic vascular stapler is passed across the inferior pulmonary vein and fired to divide it. The lower lobe is retracted inferiorly and dissection in the fissure to separate the upper and lower lobes performed. At the base of the fissure the pulmonary artery is identified and carefully dissected free. The dissection is continued until the branches to the lingula,, superior segment and the four basilar segments are identified. The arterial branches to the lower lobe are divided using the endoscopic vascular stapler. Underneath the artery the lower lobe bronchus is identified, isolated, and divided using the endoscopic tissue stapler taking care not to narrow the middle lobe bronchus. Using multiple firings of the endoscopic tissue stapler the fissures between the lower lobe and upper lobe is completely divided. The resected lower lobe is endoscopically placed in a sterile bag which is closed and then removed from the chest cavity through the accessory incision. The specimen is sent to pathology for frozen section analysis of the margin which can require 15 to 20 minutes. For lung cancer, a thoracoscopic mediastinal and regional lymphadenectomy may be performed (separately reported). Once confirmation is obtained indicating that no further surgery is required (e.g. benign lesion or margins negative if malignant) the steps for closure are begun. The anesthetist is asked to inflate the operated lung and all staple lines are assessed for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. The anesthetist is again asked to inflate the operated lung and with the thoracoscope still in place observing that the remaining lung completely re-expands. The thoracoscope is then removed. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32663				
Sample Size:	300	Resp N:	55	Response: 18.3 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	15.00	20.00	30.00
Survey RVW:		25.00	27.23	31.00	36.98
Pre-Service Evaluation Time:				60.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		60.00	143.00	155.00	180.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>170.00</u>	99231x 1.00	99232x 1.00	99233x 2.00	
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>39.00</u>	99211x 0.00	12x 1.00	13x 1.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32663	Recommended Physician Work RVU: 24.64		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		155.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>170.00</u>	99231x 1.00	99232x 1.00	99233x 2.00
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>39.00</u>	99211x 0.00	12x 1.00	13x 1.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32484	090	25.38	RUC Time

CPT Descriptor Removal of lung, other than total pneumonectomy; single segment (segmentectomy)**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34802	090	23.79	RUC Time	13,847

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44204	090	26.42	RUC Time	10,969

CPT Descriptor 2 Laparoscopy, surgical; colectomy, partial, with anastomosis

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32486	090	42.88	RUC Time

CPT Descriptor Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 19 % of respondents: 34.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32663	<u>Key Reference CPT Code:</u> 32484	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	155.00	139.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	170.0	210.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	507.00	561.00	

Other time if appropriate		
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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	3.74	3.58
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.74	3.47
--	------	------

Urgency of medical decision making	3.00	2.95
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.21	3.74
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Physical effort required	3.63	3.42
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.37	3.21
---	------	------

Outcome depends on the skill and judgment of physician	4.05	3.74
--	------	------

Estimated risk of malpractice suit with poor outcome	2.58	2.47
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.63	3.47
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Intra-Service intensity/complexity	4.05	3.84
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Post-Service intensity/complexity	3.26	2.95
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Additional Rationale and Comments

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

A survey was conducted with 56 respondents. Code 32484 was selected as the Key Reference Service, and was performed 4 times annually by the respondents, compared to 20 times for the surveyed code. The vignette was felt to be typical by 95% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 155 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 5 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

Recommending to maintain the current work value of 24.64. This code was valued in the 3rd 5 year review only for thoracoscopic lobectomy because it was the predominant procedure performed at that time. The survey supports this recommendation.

The IWP/UT of 32663 is 0.088 compared to the IWP/UT of 0.089 for the key reference code 32484, removal of lung, other than total pneumonectomy; single segment (segmentectomy). Compared to the key reference code, the expert panel felt that 32663 was appropriately valued with longer intraoperative time and higher work intensity as reflected by the IWP/UT.

Historically thoracoscopic lobectomy and segmentectomy have been grouped together. From 1993 to 2005 segmentectomies were not performed thoracoscopically. The bundling of these two procedures did not matter until the past few years. As evidenced by the current RUC valuations for the open segmentectomy and lobectomy, the work involved is slightly different. In order to capture the precision of the open codes, we decided to separate VATS lobectomy and segmentectomy to accurately reflect the work involved. The current code 32663 was recently valued in 2005 in the work review and the expert panel felt that the current value is accurate. The survey respondents delivered results suggesting that the relative value for segmentectomy was slightly lower than that for lobectomy (median of 29 versus 31 RVUs). The Expert panel felt that the new median values were too high with regard to their absolute values but appropriate with regard to their relativity. The Expert Panel felt that the valuation for 32663 at 24.64 for the lobectomy was correct and proposes that the valuation for segmentectomy be set utilizing the ratio of the 25th percentile values (26.00 and 27.23) proposed by the survey respondents. This results in the recommendation of 23.53 for the segmentectomy which results in a net savings for these codes.

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) 32663

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 5313

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 4533 Percentage 85.31 %

Specialty general surgery Frequency 524 Percentage 9.86 %

Specialty other Frequency 256 Percentage 4.81 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,995

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization for the existing code 32663 is 4342. It is estimated that of this number, 8% of the procedures (347) will be reported with code 32669 and 92% of the procedrues (3995) will be reproted with code 32663.

Specialty cardiothoracic surgery Frequency 3409 Percentage 85.33 %

Specialty general surgery Frequency 394 Percentage 9.86 %

Specialty other Frequency 192 Percentage 4.80 %

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 32663

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:32666 Tracking Number II12

Original Specialty Recommended RVU: **14.50**Presented Recommended RVU: **14.50**

Global Period: 090

RUC Recommended RVU: **14.50**

CPT Descriptor: Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral
(To report bilateral procedure, report 32666 with modifier 50)
(Do not report 32666, in conjunction with 32440, 32442, 32445, 32488, 32671)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 68-year-old female two years status post right leg resection for osteosarcoma presents with a new solitary pulmonary nodule in the right upper lobe, There is no evidence of local recurrence. Metastatic disease is suspected. The patient is referred for curative resection.

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 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the abnormal lung nodule. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord, etc.) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 or 2) if necessary are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary

are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The worrisome lung nodule is identified, and its relationship to the pulmonary vasculature and bronchial tree assessed to determine that biopsy is feasible. The lung is mobilized as needed for assistance in exposing the nodule. Using multiple firings of endoscopic tissue staplers a wedge resection of the nodule is performed removing the nodule with at least a 1- to 2 cm free margin of normal lung parenchyma. The specimen prior to removal from the chest is placed in a sterile bag to avoid trocar site contamination. As necessary hemostasis is secured with electrocautery and if needed the staple lines reinforced with suture. If necessary, sterile portions of the resected nodule are prepared and sent for appropriate microbiologic testing. The remaining portions of resected lung are sent for frozen section evaluation to obtain a histopathologic diagnosis and ensure that the nodule has been removed with free margins. The anesthetist is asked to inflate the operated lung and all staple lines are assessed for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress, and when ready the patient is discharged. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32666				
Sample Size:	300	Resp N:	55	Response: 18.3 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		2.00	15.00	25.00	45.00
Survey RVW:		11.00	14.50	19.00	24.06
Pre-Service Evaluation Time:				50.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		40.00	60.00	75.00	90.00
Immediate Post Service-Time:	30.00				
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):	60.00	99231x 1.00	99232x 0.00	99233x 1.00	
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00	14x 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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32666	Recommended Physician Work RVU: 14.50		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		75.00		
Immediate Post Service-Time:	30.00			
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):	60.00	99231x 1.00	99232x 0.00	99233x 1.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32662	090	14.99	RUC Time

CPT Descriptor Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36830	090	12.03	RUC Time	27,436

CPT Descriptor 1 Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22554	090	17.69	RUC Time	32,339

CPT Descriptor 2 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32651	090	18.78	RUC Time

CPT Descriptor Thoracoscopy, surgical; with partial pulmonary decortication**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 30.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32666	<u>Key Reference CPT Code:</u> 32662	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	75.00	98.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	60.0	40.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	317.00	350.00	

Other time if appropriate		
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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	3.35	3.18
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.53	3.35
--	------	------

Urgency of medical decision making	2.94	2.82
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.24	3.12
--------------------------	------	------

Physical effort required	3.41	3.06
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.88	3.18
---	------	------

Outcome depends on the skill and judgment of physician	3.29	3.41
--	------	------

Estimated risk of malpractice suit with poor outcome	2.59	2.65
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.12	3.35
----------------------------------	------	------

Intra-Service intensity/complexity	3.12	3.29
------------------------------------	------	------

Post-Service intensity/complexity	2.71	2.71
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Additional Rationale and Comments

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

A survey was conducted with 55 respondents. Code 32662 was selected as the Key Reference Service, and was performed 8 times annually by the respondents, compared to 25 times for the surveyed code. The vignette was felt to be typical by 95% of the respondents, and the procedure was typically performed as an inpatient.

An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 75 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 3 days as supported by the survey. The expert panel assigned a typical hospital visit pattern consistent with the other thoracoscopic lung resection codes and a discharge day, supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

We are recommending a work RVU of 14.50 for this code, which is the 25th percentile of the survey values. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family and includes an appropriate relationship to the comparable open code.

The IWPUP of 32666 is 0.093 is comparable to the IWPUP of 0.083 for the key reference code 32662, thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass. It is also comparable with the IWPUP of the other thoracoscopic pulmonary resection code 32663 0.105

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) 32657

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 cardiothoracic surgery

How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 8734

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 7861 Percentage 90.00 %

Specialty general surgery Frequency 698 Percentage 7.99 %

Specialty other Frequency 175 Percentage 2.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,551If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The total utilization of the current code 32657 for 2009 is 9029. Of this 72% will go to 32666.

Specialty cardiothoracic surgery Frequency 5241 Percentage 80.00 %

Specialty general surgery Frequency 937 Percentage 14.30 %

Specialty other Frequency 373 Percentage 5.69 %

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 numberIf 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. 32662

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

CPT Code:32667 Tracking Number II13

Original Specialty Recommended RVU: **3.81**Presented Recommended RVU: **3.81**

Global Period: ZZZ

RUC Recommended RVU: **3.00**

CPT Descriptor: Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass or nodule), each additional resection, ipsilateral (List separately in addition to code for primary procedure)

(Report 32667 only in conjunction with 32666)

(Do not report 32667 in conjunction with 32440, 32442, 32445, 32488, 32671)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old female two years status post right leg resection for osteosarcoma presents with a nodule in the right upper lobe and an additional nodule in the right lower lobe. There is no evidence of local recurrence and patient is referred for curative resections

The patient has a thoracoscopic wedge resection of the right upper lobe nodule (separately reported). A separate wedge resection of the right lower lobe nodule is performed

For this procedure consider only the work of the additional wedge resection in the separate lobe. This is an add-on service.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: There is no additional pre-service work

Description of Intra-Service Work: If there is more than one lung nodule present, then after the first wedge resection is performed and histopathologic diagnosis confirmed, wedge resection of the additional nodule(s) may be indicated. This entails performing the additional necessary wedge resection(s) in the same fashion as the initial wedge resection utilizing multiple firings of the endoscopic tissue staplers. Some nodules may require electrocautery resection with suture closure of the lung parenchymal defect. All nodules should be removed with ideally 1- to 2 cm free margin. Each specimen prior to removal from the chest is placed in a sterile bag to avoid trocar site contamination. Each of the resected nodules should be sent for histopathologic examination. The anesthetist is asked to inflate the operated lung and all resection sites are assessed for both hemostasis and air leakage.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32667				
Sample Size:	300	Resp N:	44	Response: 14.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	8.00	10.00	22.00
Survey RVW:		1.25	3.81	4.59	7.98
Pre-Service Evaluation Time:				8.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	20.00	25.00	35.00
Immediate Post Service-Time:		<u>0.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:	32667	Recommended Physician Work RVU: 3.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		25.00		
Immediate Post Service-Time:		<u>0.00</u>		
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32501	ZZZ	4.68	RUC Time

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
63048	ZZZ	3.47	RUC Time	120,569

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22525	ZZZ	4.47	RUC Time	13,121

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
44213	ZZZ	3.50	RUC Time

CPT Descriptor Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to 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: 9 % of respondents: 20.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32667	<u>Key Reference CPT Code:</u> 32501	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	25.00	25.00	
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	25.00	25.00
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	3.22	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.22	3.22
Urgency of medical decision making	3.22	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.33	3.56
Physical effort required	3.22	3.22

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.11	3.67
Outcome depends on the skill and judgment of physician	3.22	3.67
Estimated risk of malpractice suit with poor outcome	2.67	2.89

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.11	3.22
Intra-Service intensity/complexity	3.33	3.78
Post-Service intensity/complexity	2.89	3.11

Additional Rationale and Comments

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

A survey was conducted with 44 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 10 times for the surveyed code. The vignette was felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time 25 minutes.

Compared to the key reference code 32501, the expert panel felt 32667 took the same amount of time but had less intense intraoperative work.

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.

FREQUENCY INFORMATION

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

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

Specialty cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 873

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 699 Percentage 80.06 %

Specialty general surgery Frequency 125 Percentage 14.31 %

Specialty other Frequency 49 Percentage 5.61 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 655
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. the utilization estimate is new RVUs not currently reported

Specialty cardiothoracic surgery	Frequency 524	Percentage 80.00 %
Specialty general surgery	Frequency 94	Percentage 14.35 %
Specialty other	Frequency 37	Percentage 5.64 %

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

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. 33517

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

CPT Code:32668 Tracking Number II14

Original Specialty Recommended RVU: **4.00**Presented Recommended RVU: **4.00**

Global Period: ZZZ

RUC Recommended RVU: **4.00**

CPT Descriptor: Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection (List separately in addition to code for primary procedure)

(Report 32668 in conjunction with 32440, 32442, 33245, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32669, 32663, 32670, 32671)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62 yo male smoker is found to have a growing left spiculated pulmonary nodule now measuring 3 cm in size. There is no evidence of metastatic disease. Pulmonary function is normal. Resection is indicated.

The patient undergoes a thoracoscopic diagnostic wedge resection to be followed by an appropriate more extensive resection (reported separately) based upon intraoperative pathology findings. This service represents only the additional services of the thoracoscopic diagnostic wedge resection in a patient who goes on to have a more extensive lung resection procedure based upon the pathology findings.

For this procedure consider only the work of the thoracoscopic diagnostic wedge resection that is sent for intraoperative pathology. This is an add-on service.

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 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: There is no additional pre-service work.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 or 2) if necessary are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes both visual inspection and palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The worrisome lung nodule is located and its relationship to the pulmonary vasculature and bronchial tree assessed to determine

that resection is feasible. The lung is mobilized as needed for assistance in exposing the nodule. Using multiple firings of endoscopic tissue staplers a wedge resection of the nodule is performed removing the nodule with at least a 1- to 2 cm margin of normal lung parenchyma. The specimen prior to removal from the chest is placed in a sterile bag to avoid trocar site contamination. As necessary hemostasis is secured with electrocautery and if needed the staple lines reinforced with suture. If necessary, sterile portions of the resected nodule are prepared and sent for appropriate microbiologic testing. The remaining portions of resected lung are sent for frozen section evaluation to obtain a histopathologic diagnosis. If lung cancer is confirmed, then anatomic resection (eg, VATS or open segmentectomy, lobectomy, pneumonectomy) (separately reported) may be indicated.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32668				
Sample Size:	300	Resp N:	44	Response: 14.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	8.00	20.00	25.00
Survey RVW:		1.25	4.00	5.25	8.75
Pre-Service Evaluation Time:				10.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	20.00	30.00	45.00
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
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:	32668	Recommended Physician Work RVU: 4.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		30.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32501	ZZZ	4.68	RUC Time

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
63048	ZZZ	3.47	RUC Time	120,569

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22525	ZZZ	4.47	RUC Time	13,121

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
44213	ZZZ	3.50	RUC Time

CPT Descriptor Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to 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: 10 % of respondents: 22.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32668	<u>Key Reference CPT Code:</u> 32501	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	25.00	
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	25.00
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	3.40	3.10
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.30	3.10
--	------	------

Urgency of medical decision making	3.30	3.40
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.60
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Physical effort required	3.20	3.20
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.20	3.60
---	------	------

Outcome depends on the skill and judgment of physician	3.30	3.60
--	------	------

Estimated risk of malpractice suit with poor outcome	2.80	2.80
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.10	3.20
----------------------------------	------	------

Intra-Service intensity/complexity	3.40	3.70
------------------------------------	------	------

Post-Service intensity/complexity	2.90	2.80
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Additional Rationale and Comments

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

A survey was conducted with 44 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 20 times for the surveyed code. The vignette was felt to be typical by 95% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time 30 minutes.

We are recommending a work RVU of 4.00 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32501, the expert panel felt 32668 took slightly longer and had less intensity.

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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 32602 and 32657

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1600

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 1283 Percentage 80.18 %

Specialty general surgery Frequency 224 Percentage 14.00 %

Specialty other Frequency 93 Percentage 5.81 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,200
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is estimated that 5% of the open and thoracoscopic lobectomies are preceded by a diagnostic thoracoscopic wedge resection.

Specialty cardiothoracic surgery Frequency 960 Percentage 80.00 %

Specialty general surgery Frequency 168 Percentage 14.00 %

Specialty other Frequency 72 Percentage 6.00 %

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

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. 33572

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

CPT Code: 32669 Tracking Number II15

Original Specialty Recommended RVU: **23.53**Presented Recommended RVU: **23.53**

Global Period: 090

RUC Recommended RVU: **23.53**

CPT Descriptor: Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78-year-old male smoker with severe emphysema present with nonsmall cell lung cancer limited to the superior segment of the left lower lobe. Patient is felt not to be a candidate for lobectomy and segmental resection is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the lung cancer. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (3 or 4) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion as is the larger accessory incision. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest

and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The cancer in the superior segment of the lower lobe is identified. The lung is retracted superiorly to expose the diaphragmatic surface. The inferior pulmonary ligament is divided with electrocautery, and the mediastinal pleura dissected away from the inferior pulmonary vein anteriorly and posteriorly. A right angle clamp is used to carefully dissect around the inferior pulmonary vein avoiding the superior pulmonary vein. The superior segmental vein branch of the inferior pulmonary vein is identified and separately isolated. The endoscopic vascular stapler is passed across the superior segmental vein and fired to divide it. The lower lobe is retracted inferiorly and dissection in the fissure to separate the upper and lower lobes performed. At the base of the fissure the pulmonary artery is identified and carefully dissected free. The dissection is continued until the branches to the superior segment of the lower lobe and the four basilar segments are identified. The arterial branch(s) to the superior segment is divided using the endoscopic vascular stapler. Underneath the artery the superior segmental bronchus to the lower lobe is identified, isolated, and divided using the endoscopic tissue stapler taking care not to narrow the basilar segmental bronchi. Using multiple firings of the endoscopic tissue stapler the fissures between the superior segment of the lower lobe and the upper lobe, and superior segment and the basilar segments are divided. The resected superior segment is endoscopically placed in a sterile bag which is closed and then removed from the chest cavity through the accessory incision. The specimen is sent to pathology for frozen section analysis of the margin which can require 15 to 20 minutes. For lung cancer, a thoroscopic mediastinal and regional lymphadenectomy is performed (separately reported). Once confirmation is obtained indicating that no further surgery is required (e.g. benign lesion or margins negative if malignant) the steps for closure are begun. The anesthetist is asked to inflate the operated lung and all staple lines are assessed for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. The anesthetist is again asked to inflate the operated lung and with the thoracoscope still in place observing that the remaining lung completely re-expands. The thoracoscope is then removed. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32669				
Sample Size:	300	Resp N:	54	Response: 18.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	2.00	5.00	8.00
Survey RVW:		17.62	26.00	29.00	35.00
Pre-Service Evaluation Time:				60.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		60.00	120.00	150.00	180.00
Immediate Post Service-Time:	<u>30.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>170.00</u>	99231x 1.00	99232x 1.00	99233x 2.00	
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>39.00</u>	99211x 0.00	12x 1.00	13x 1.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32669	Recommended Physician Work RVU: 25.53		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		150.00		
Immediate Post Service-Time:	<u>30.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>170.00</u>	99231x 1.00	99232x 1.00	99233x 2.00
Discharge Day Mgmt:	<u>38.00</u>	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>39.00</u>	99211x 0.00	12x 1.00	13x 1.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32484	090	25.38	RUC Time

CPT Descriptor Removal of lung, other than total pneumonectomy; single segment (segmentectomy)**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34802	090	27.39	RUC Time	13,487

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44204	090	26.42	RUC Time	10,969

CPT Descriptor 2 Laparoscopy, surgical; colectomy, partial, with anastomosis

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
44207	090	31.92	RUC Time

CPT Descriptor Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 27 % of respondents: 50.0 %****TIME ESTIMATES (Median)**

	<u>CPT Code:</u> 32669	<u>Key Reference CPT Code:</u> 32484	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	150.00	139.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	170.0	210.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	502.00	561.00	

Other time if appropriate		
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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	3.56	3.59
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.63
--	------	------

Urgency of medical decision making	2.81	2.89
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.04	3.81
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Physical effort required	3.56	3.52
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.33	3.33
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Outcome depends on the skill and judgment of physician	3.74	3.78
--	------	------

Estimated risk of malpractice suit with poor outcome	2.74	2.89
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.56	3.67
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Intra-Service intensity/complexity	4.19	3.96
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Post-Service intensity/complexity	3.15	3.19
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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.*

A survey was conducted with 54 respondents. Code 32484 was selected as the Key Reference Service, and was performed 4 times annually by the respondents, compared to 8 times for the surveyed code. The vignette was felt to be typical by 96% of the respondents, and the procedure was typically performed as an inpatient.

An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 150 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 5 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

In order to achieve budget neutrality we applied the ratio of the expert panel recommendations (26 for thoracoscopic segmentectomy and 27.23 for thoracoscopic lobectomy) to the current and recommended value of 24.64 for the thoracoscopic lobectomy. This resulted in our recommended value for thoracoscopic segmentectomy of 23.53.

The IWPOT of 32669 is 0.084 compared to the IWPOT of 0.089 for the key reference code 32484, removal of lung, other than total pneumonectomy; single segment (segmentectomy). Compared to the key reference code, the expert panel felt that 32669 was appropriately valued with longer intraoperative time.

Historically thoracoscopic lobectomy and segmentectomy have been grouped together. From 1993 to 2005 segmentectomies were not performed thoracoscopically. The bundling of these two procedures did not matter until the past few years. As evidenced by the current RUC valuations for the open segmentectomy and lobectomy, the work involved is slightly different. In order to capture the precision of the open codes, we decided to separate VATS lobectomy and segmentectomy to accurately reflect the work involved. The current code 32663 was recently valued in 2005 in the work review and the expert panel felt that the current value is accurate. The survey respondents delivered results suggesting that the relative value for segmentectomy was slightly lower than that for lobectomy (median of 29 versus 31 RVUs). The Expert panel felt that the new median values were too high with regard to their absolute values but appropriate with regard to their relativity. The Expert Panel felt that the valuation for 32663 at 24.64 for the lobectomy was correct and proposes that the valuation for segmentectomy be set utilizing the ratio of the 25th percentile values (26.00 and 27.23) proposed by the survey respondents. This results in the recommendation of 23.53 for the segmentectomy which results in a net savings for these codes.

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) 32663

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 462

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 394 Percentage 85.28 %

Specialty general surgery Frequency 46 Percentage 9.95 %

Specialty other Frequency 22 Percentage 4.76 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 347

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization for the existing code 32663 is 4342. It is estimated that of this number, 8% of the procedures (347) will be reported with code 32669 and 92% of the procedrues (3995) will be reproted with code 32663.

Specialty cardiothoracic surgery Frequency 296 Percentage 85.30 %

Specialty general surgery Frequency 34 Percentage 9.79 %

Specialty other Frequency 17 Percentage 4.89 %

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

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. 32663

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

CPT Code:32670 Tracking Number II17

Original Specialty Recommended RVU: **29.75**Presented Recommended RVU: **29.75**

Global Period: 090

RUC Recommended RVU: **28.52**

CPT Descriptor: Thoracoscopy, surgical; with removal of two lobes (bilobectomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 69-year-old male presents with centrally located nonsmall cell lung cancer which involves both the middle and lower lobe orifices. Bilobar resection (combined resection of middle and lower lobes) is required.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the lung cancer. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc..) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial right trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (3 or 4) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion as is the larger accessory incision. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest

and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The central lung cancer is identified. The lung is retracted superiorly to expose the diaphragmatic surface. The inferior pulmonary ligament is divided with electrocautery, and the mediastinal pleura dissected away from the inferior pulmonary vein anteriorly and posteriorly. A right angle clamp is used to carefully dissect around the inferior pulmonary vein away from the superior pulmonary vein to the upper lobe, The endoscopic vascular stapler is passed across the inferior pulmonary vein and fired to divide it. In a similar fashion the middle lobe vein is dissected free and isolated from the superior pulmonary vein. It too is divided utilizing the endoscopic vascular stapler. The lower lobe is retracted inferiorly and dissection in the fissure to separate the upper and lower lobes performed. At the base of the fissure the pulmonary artery is identified and carefully dissected free. The dissection is continued until the branches to the middle lobe, superior segment and the four basilar segments are identified. The arterial branches are divided using the endoscopic vascular stapler. Underneath the artery the bronchus intermedius is identified, isolated, and divided using the endoscopic tissue stapler taking care not to narrow the upper lobe bronchus. Using multiple firings of the endoscopic tissue stapler the fissures between the lower lobe and upper lobe, and upper lobe and middle lobe are divided. The resected middle and lower lobes are endoscopically placed in a sterile bag which is closed and then removed from the chest cavity through the accessory incision. The specimen is sent to pathology for frozen section analysis of the margin which can require 15 to 20 minutes. For lung cancer, a thoracoscopic mediastinal and regional lymphadenectomy may be performed (separately reported). Once confirmation is obtained indicating that no further surgery is required (e.g. benign lesion or margins negative if malignant) the steps for closure are begun. The anesthetist is asked to inflate the operated lung and all staple lines are assessed for both hemostasis and air leakage. The lung again deflated and the chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. The anesthetist is again asked to inflate the operated lung and with the thoracoscope still in place observing that the remaining lung completely re-expands. The thoracoscope is then removed. A surgical pause is conducted while an instrument, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32670				
Sample Size:	300	Resp N:	55	Response: 18.3 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	1.00	2.00	5.00
Survey RVW:		23.00	29.75	35.00	40.75
Pre-Service Evaluation Time:				60.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		60.00	150.00	180.00	205.00
Immediate Post Service-Time:	30.00				
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):	170.00	99231x 1.00	99232x 1.00	99233x 2.00	
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00	14x 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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32670	Recommended Physician Work RVU: 28.52		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		180.00		
Immediate Post Service-Time:	30.00			
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):	170.00	99231x 1.00	99232x 1.00	99233x 2.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32486	090	42.88	RUC Time

CPT Descriptor Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34802	090	23.79	RUC Time	13,487

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44204	090	26.42	RUC Time	10,969

CPT Descriptor 2 Laparoscopy, surgical; colectomy, partial, with anastomosis

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32484	090	25.38	RUC Time

CPT Descriptor Removal of lung, other than total pneumonectomy; single segment (segmentectomy)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 22 % of respondents: 40.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32670	<u>Key Reference CPT Code:</u> 32486	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	180.00	240.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	170.0	360.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	532.00	812.00	

Other time if appropriate		
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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	3.82	3.77
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.91	3.95
--	------	------

Urgency of medical decision making	3.41	3.32
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.45	4.36
--------------------------	------	------

Physical effort required	3.91	3.77
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	4.00
---	------	------

Outcome depends on the skill and judgment of physician	4.41	4.32
--	------	------

Estimated risk of malpractice suit with poor outcome	3.45	3.27
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.86	3.77
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Intra-Service intensity/complexity	4.27	4.27
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Post-Service intensity/complexity	3.77	3.77
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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.*

A survey was conducted with 55 respondents. Code 32486 was selected as the Key Reference Service, and was performed 3 times annually by the respondents, compared to 2 times for the surveyed code. The vignette was felt to be typical by 89% of the respondents, and the procedure was typically performed as an inpatient.

An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 180 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 5 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

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) 32482

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Rarely

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 391

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 3343 Percentage 854.98 %

Specialty general surgery	Frequency 39	Percentage 9.97 %
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Specialty other	Frequency 19	Percentage 4.85 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 294
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization for the open code 32482 is 890. It is estimated that 1/3 of these procedures (294) will be reported using the new code 32670.

Specialty cardiothoracic surgery	Frequency 251	Percentage 85.37 %
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Specialty general surgery	Frequency 29	Percentage 9.86 %
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Specialty other	Frequency 14	Percentage 4.76 %
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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

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. 32652

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

CPT Code: 32671 Tracking Number II18

Original Specialty Recommended RVU: **31.92**Presented Recommended RVU: **31.92**

Global Period: 090

RUC Recommended RVU: **31.92**

CPT Descriptor: Thoracoscopy, surgical; with removal of lung (pneumectomy)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 64-year-old female presents with a squamous carcinoma of the left upper lobe involving the left mainstem bronchus requiring pneumectomy for complete excision.

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 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the lung cancer. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (3 or 4) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion as is the larger accessory incision. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent if appropriate for cytology and microbiology. The chest and lung are explored which includes both visual inspection and/or palpation of the parietal pleura, visceral

pleura, diaphragm, mediastinum, and lung. Abnormalities of the visceral and parietal pleura and lung are noted. Retract lung superiorly to expose the diaphragmatic surface. The inferior pulmonary ligament is divided with electrocautery, and the mediastinal pleura dissected away from the inferior pulmonary vein anteriorly and posteriorly. A right angle clamp is used to carefully dissect around the inferior pulmonary vein away from the superior pulmonary vein. The endoscopic vascular stapler is passed across the inferior pulmonary vein and fired to divide it. A right angle clamp is used to carefully dissect around the superior pulmonary vein, and the endoscopic vascular stapler is passed across the superior pulmonary vein and fired to divide it. The lung is retracted inferiorly and posteriorly and the pulmonary artery identified and carefully dissected free. The pulmonary artery is encircled with a vascular loop. The pulmonary artery is divided with the endoscopic vascular stapler. The mainstem bronchus is dissected free. For lung cancer, a thoracoscopic mediastinal and regional lymphadenectomy is performed (separately reported). The mainstem bronchus is then divided with the endoscopic tissue stapler. The resected lung is endoscopically placed in a sterile bag which is closed and then removed from the chest cavity through the accessory incision. The specimen is sent to pathology for frozen section analysis of the margin which can require 15 to 20 minutes. Once confirmation is obtained indicating that no further surgery is required (e.g. benign lesion or margins negative if malignant) the steps for closure are begun. The anesthetist is asked to inflate the operated side and the bronchial staple line is assessed for air leakage. All vascular staple lines are assessed for hemostasis. The chest cavity is irrigated with several liters of saline. A chest tube(s) is inserted through a separate interspace incision(s) to provide for stabilization of the mediastinum. All trocar incisions are assessed for hemostasis. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch. With the patient supine and positive pressure from the anesthetist the chest tube is removed and pursestring skin suture tied.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. These patients are usually in an ICU on the first postoperative day. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32671				
Sample Size:	300	Resp N:	55	Response: 18.3 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	0.00	0.00	1.00
Survey RVW:		27.00	31.92	38.00	44.77
Pre-Service Evaluation Time:				60.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		60.00	140.00	180.00	180.00
Immediate Post Service-Time:	30.00				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	70.00	99291x 1.00	99292x 0.00		
Other Hospital time/visit(s):	170.00	99231x 1.00	99232x 1.00	99233x 2.00	
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00	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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32671	Recommended Physician Work RVU: 31.92		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		180.00		
Immediate Post Service-Time:	30.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	70.00	99291x 1.00	99292x 0.00	
Other Hospital time/visit(s):	170.00	99231x 1.00	99232x 1.00	99233x 2.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32486	090	42.88	RUC Time

CPT Descriptor Removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
61510	090	30.83	RUC Time	6,697

CPT Descriptor 1 Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
35646	090	32.98	RUC Time	2,387

CPT Descriptor 2 Bypass graft, with other than vein; aortobifemoral

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32652	090	29.13	RUC Time

CPT Descriptor Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 22 % of respondents: 40.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32671	<u>Key Reference CPT Code:</u> 32486	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	180.00	240.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	70.0	0.00	
Median Other Hospital Visit Time	170.0	360.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	602.00	812.00	

Other time if appropriate		
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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	4.10	3.62
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.24	3.95
--	------	------

Urgency of medical decision making	3.62	3.29
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.33	4.29
--------------------------	------	------

Physical effort required	4.10	3.81
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.52	3.95
---	------	------

Outcome depends on the skill and judgment of physician	4.43	4.10
--	------	------

Estimated risk of malpractice suit with poor outcome	3.43	3.10
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	4.33	3.99
----------------------------------	------	------

Intra-Service intensity/complexity	4.48	4.29
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Post-Service intensity/complexity	4.29	3.86
-----------------------------------	------	------

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.*

A survey was conducted with 55 respondents. Code 32486 was selected as the Key Reference Service, and was performed 2 times annually by the respondents, compared to 0 times for the surveyed code. The vignette was felt to be typical by 85% of the respondents, and the procedure was typically performed as an inpatient.

An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 180 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 6 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

We are recommending a work RVU of 31.92 for this code, which is the 25th percentile of the survey values. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

The IWPOT of 32671 is 0.092 compared to the IWPOT of 0.102 for the key reference code 32486, removal of lung, other than total pneumonectomy; with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy). Compared to the key reference code, the expert panel felt that 32671 was appropriately valued with shorter intraoperative time and less work intensity as reflected by the IWPOT.

Separate SORs have been provided for the 0 performance rate to show the aggregate data, the data for those with experience only and the data for those with no experience. The reference code for aggregate data is 32486, the reference code for those with no experience is also 32486, the reference code for those with experience is 32422.

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) 32999 or 32440

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Rarely

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 27

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 23 Percentage 85.18 %

Specialty general surgery Frequency 2 Percentage 7.40 %

Specialty other Frequency 2 Percentage 7.40 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2% of current 2009 Medicare utilization of 32440.

Specialty cardiothoracic surgery Frequency 17 Percentage 85.00 %

Specialty general surgery Frequency 2 Percentage 10.00 %

Specialty other Frequency 1 Percentage 5.00 %

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

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. 32503

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

CPT Code: 32672 Tracking Number II19

Original Specialty Recommended RVU: **27.00**Presented Recommended RVU: **27.00**

Global Period: 090

RUC Recommended RVU: **27.00**

CPT Descriptor: Thoracoscopy, surgical; with resection-plectomy for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 45-year-old woman with severe COPD and dyspnea presents for LVRS. She has upper lobe predominant emphysema and is an appropriate candidate for LVRS

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 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the emphysematous lung. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then places the patient in a lateral decubitus position, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (2 or 3) are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion as is the larger accessory incision. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are carefully freed so as not to injure the severely emphysematous lung. Pleural fluid if present and if

appropriate is sent if appropriate for cytology and microbiology. The chest and lung are explored. The target areas of severe emphysematous lung are noted and using many applications of the endoscopic stapling device with specially applied buttressing material a significant portion of emphysematous lung is removed. Typically about two-thirds of the affected lobe is removed. On the ipsilateral side, other areas of destroyed lung may be removed as well from the other lobe(s) (not separately reported). The specimens are removed from the chest in a sterile bag and sent to pathology. The staple lines are reinforced as necessary with additional staple applications, suturing, or by the application of tissue sealants. The anesthetist is asked to inflate the operated lung and all staple lines are assessed for both hemostasis and air leakage. A pleural tent or pleurodesis is done if needed. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. All trocar incisions are assessed for hemostasis. The anesthetist is again asked to inflate the operated lung and with the thoracoscope still in place observing that the remaining lung completely re-expands. The thoracoscope is then removed. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress, and when ready the patient is discharged. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for on-going outpatient pulmonary rehabilitation and additional follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32672				
Sample Size:	300	Resp N:	54	Response: 18.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	1.00	3.00	5.00
Survey RVW:		14.99	27.00	28.00	32.83
Pre-Service Evaluation Time:				60.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				18.00	
Intra-Service Time:		45.00	90.00	120.00	120.00
Immediate Post Service-Time:	30.00				
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):	265.00	99231x 1.00	99232x 2.00	99233x 3.00	
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00	14x 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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32672	Recommended Physician Work RVU: 27.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		120.00		
Immediate Post Service-Time:	30.00			
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):	265.00	99231x 1.00	99232x 2.00	99233x 3.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32141	090	27.18	RUC Time

CPT Descriptor Thoracotomy, major; with excision-plication of bullae, with or without any pleural 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34802	090	23.79	RUC Time	13,487

CPT Descriptor 1 Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44204	090	26.42	RUC Time	10,969

CPT Descriptor 2 Laparoscopy, surgical; colectomy, partial, with anastomosis

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32652	090	29.13	RUC Time

CPT Descriptor Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 51.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32672	<u>Key Reference CPT Code:</u> 32141	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	120.00	116.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	265.0	345.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	567.00	673.00	
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	3.43	3.36
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.64
--	------	------

Urgency of medical decision making	2.39	2.46
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.39	3.25
--------------------------	------	------

Physical effort required	3.29	3.21
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.61	3.54
---	------	------

Outcome depends on the skill and judgment of physician	3.64	3.50
--	------	------

Estimated risk of malpractice suit with poor outcome	3.07	2.96
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.82	3.68
----------------------------------	------	------

Intra-Service intensity/complexity	3.57	3.36
------------------------------------	------	------

Post-Service intensity/complexity	3.54	3.50
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Additional Rationale and Comments

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

A survey was conducted with 54 respondents. Code 32141 was selected as the Key Reference Service, and was performed 2 times annually by the respondents, compared to 3 times for the surveyed code. The vignette was felt to be typical by 93% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey intraservice time of 120 minutes which is the median time and immediate post service time of 30 minutes are recommended. The code has a recommended length of stay of 7 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

We are recommending a work RVU of 27.00 for this code, which is the 25th percentile of the survey values. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

The IWPUT of 32672 is 0.106 compared to the IWPUT of 0.081 for the key reference code 32141, thoracotomy, major; with excision-plectomy of bullae, with or without any pleural procedure. Compared to the key reference code, the expert panel felt that 32672 was appropriately valued with similar intraoperative time and higher work intensity as reflected by the IWPUT. The higher work intensity reflects the underlying severity of the lung disease and increased risk of post-operative broncho-pleural fistulae.

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) 32999 and 32491

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 cardiothoracic surgery

How often? Sometimes

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

CPT Code: 32673 Tracking Number II20

Original Specialty Recommended RVU: **21.13**Presented Recommended RVU: **21.13**

Global Period: 090

RUC Recommended RVU: **21.13**

CPT Descriptor: Thoracotomy, surgical; with resection of thymus, unilateral or bilateral
(For open thymectomy see 60520, 60521, 60522)
(For open excision mediastinal cyst see 39200, for open excision mediastinal tumor use 39220)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 35-year-old male with myasthenia gravis is referred for thymectomy.

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 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 100%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Within the 24 hours prior to surgery, the patient is seen and examined to rule out concurrent illness and any contraindication to surgery. Medical records are reviewed including x-rays identifying the mediastinum. The patient and family are counseled and operative consent is obtained. Preoperative orders are written. Operative site marking is performed. The surgeon dresses and waits for the institution of appropriate monitoring, vascular access, and induction of anesthesia. The surgeon then properly positions the patient on the operating table, and preps the patient after which the surgeon scrubs, gowns, and drapes the patient. The surgeon then assures that: 1) all equipment necessary for thoracoscopy (thoracoscope, fiberoptic light cord, video camera, cautery cord etc.) is placed in the field, assembled and fixed to the drapes, 2) the ends of the camera, light and cautery cords are passed off in sterile fashion to circulating nurse for attachment of light and video and cautery equipment, 3) the equipment is activated and the settings adjusted appropriately (focus, light settings, cautery settings). The pre-incision surgical pause is completed. The anesthesiologist is instructed to institute single lung ventilation.

Description of Intra-Service Work: The site for the initial trocar site is identified and anesthetized with local anesthetic. An incision is made, and using a combination of sharp, cautery, and blunt dissection the pleural cavity carefully entered. The parietal pleura is palpated, a trocar inserted under direct vision, and the thoracoscope advanced into the pleural cavity. Initial visual exploration is performed. The sites for all additional trocar incisions (1 or 2) if necessary are identified and are anesthetized with local anesthetic. The additional trocar incisions are made in a similar fashion. Access ports as necessary are placed at each incision site for the passage of instruments. Adhesions between the lung and chest wall are freed. Pleural fluid if present and if appropriate is sent for cytology and microbiology. The chest and lung are explored which includes

both visual inspection and/or palpation of the parietal pleura, visceral pleura, diaphragm, mediastinum, and lung. The thymus and attached mediastinal fat is carefully dissected off the pericardium from the diaphragm up to the innominate vein. The phrenic nerve is carefully protected. The innominate vein is skeletonized and venous tributaries are ligated or clipped. The two cervical lobes are dissected out above the innominate vein and brought down into the mediastinal space. The pleura on the opposite side is dissected off the thymus and the remainder of the thymus separated from its mediastinal attachments. On occasion it may be necessary to place a trocar in the contralateral pleural space to complete the dissection of the contralateral portion of the thymus gland. The thymus is placed in a sterile bag to avoid trocar site contamination. The operative field is inspected for adequate hemostasis. The chest cavity is irrigated. A chest tube(s) is inserted through a separate interspace incision(s) to provide evacuation of air and fluid from the chest. The anesthetist is asked to inflate the lung. A surgical pause is conducted while an instrumentation, needle, and sponge count is completed and confirmed by the surgeon. Each incision is closed with multiple layers of suture for the muscle, and the skin reapproximated with a subcuticular stitch.

Description of Post-Service Work: Dressings are applied and patient stability ensured. The operative note is dictated and postoperative orders written. The procedure's outcome is discussed with the family, nurses, the patient and other physicians. Postoperative lab values and x-rays are reviewed. Patient is carefully monitored in the hospital and further postoperative orders and notes are written daily with regards to the chest surgery. The thoracic surgeon monitors the wound, chest x-ray, and chest tube fluid output and air leakage. The chest tube is removed when appropriate. Patient, family and nursing staff are kept informed regarding progress, and when ready the patient is discharged. Discharge entails appropriate documentation, patient and family counseling, dietary instruction, providing prescriptions, and arranging for on-going outpatient pulmonary rehabilitation and additional follow-up. The patient is followed in the outpatient clinic

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	32673				
Sample Size:	300	Resp N:	54	Response: 18.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	0.00	2.00	5.00
Survey RVW:		15.00	21.13	27.75	30.40
Pre-Service Evaluation Time:				60.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		60.00	120.00	150.00	180.00
Immediate Post Service-Time:	30.00				
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):	115.00	99231x 1.00	99232x 1.00	99233x 1.00	
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00	14x 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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	32673	Recommended Physician Work RVU: 21.13		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		150.00		
Immediate Post Service-Time:	30.00			
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):	115.00	99231x 1.00	99232x 1.00	99233x 1.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	39.00	99211x 0.00	12x 1.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
39220	090	19.55	RUC Time

CPT Descriptor Excision of mediastinal tumor**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44160	090	20.89	RUC Time	17,746

CPT Descriptor 1 Colectomy, partial, with removal of terminal ileum with ileocolostomy

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
44140	090	22.59	RUC Time	27,635

CPT Descriptor 2 Colectomy, partial; with anastomosis

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
60520	090	17.16	RUC Time

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

Number of respondents who choose Key Reference Code: 10 % of respondents: 18.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32673	<u>Key Reference CPT Code:</u> 39220	<u>Source of Time</u> RUC Time
Median Pre-Service Time	75.00	95.00	
Median Intra-Service Time	150.00	124.00	
Median Immediate Post-service Time	30.00	40.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	115.0	100.00	
Median Discharge Day Management Time	38.0	38.00	
Median Office Visit Time	39.0	39.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	447.00	436.00	
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	3.10	3.40
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.60
--	------	------

Urgency of medical decision making	3.00	3.20
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.90	3.60
--------------------------	------	------

Physical effort required	3.60	3.40
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.20	3.20
---	------	------

Outcome depends on the skill and judgment of physician	3.80	3.90
--	------	------

Estimated risk of malpractice suit with poor outcome	2.70	2.70
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.60	3.70
----------------------------------	------	------

Intra-Service intensity/complexity	3.90	3.90
------------------------------------	------	------

Post-Service intensity/complexity	3.10	3.00
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Additional Rationale and Comments

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

A survey was conducted with 54 respondents. 39220 was selected as the Key Reference Service, and was performed 3 times annually by the respondents, compared to 2 times for the surveyed code. The vignette was felt to be typical by 91% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results and selected Pre-time package 4 (facility- difficult patient/difficult procedure) as appropriate, with the following modifications to the package time:

Evaluation: No change

Positioning: Add 12 minutes (total = 15 min) to account for lateral decubitus positioning. Scrub, dress, wait: No change.

The survey median intraservice time (150 minutes) and immediate post service time (30 minutes) are recommended, as it a length of stay of 4 days as supported by the survey. The expert panel assigned a typical hospital visit pattern and a discharge day, also supported by the survey. The typical patient is seen 2 times in the office setting, with a 99213 and 99212 recommended by the expert panel.

We are recommending a work RVU of 21.13 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 39220, the expert panel felt 32673 took longer and was of similar intensity (0.081 compared to 0.085 for the reference code). The postoperative care was judged to be about the same and the requirement for office visits similar. Two office visits are required to ensure proper wound healing, remove sutures, monitor the chest radiograph, discuss pathologic results with the patient, monitor the neurologic status of the patient and communicate with the referring neurologist.

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) 32999, 60521 or 60522

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 cardiothoracic surgery How often? Sometimes

Specialty general surgery How often? Rarely

Specialty other How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 213

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 180 Percentage 84.50 %

Specialty general surgery Frequency 19 Percentage 8.92 %

Specialty other Frequency 15 Percentage 7.04 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 162

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The open thymectomy codes are currently reported using codes 60521 (319) and 60522 (167) for a total volume of 2009 utilization of 486. It is estimated that 1/3 of each these procedures (162) will be performed using the new code 32673.

Specialty cardiothoracic surgery Frequency 135 Percentage 83.33 %

Specialty general surgery Frequency 14 Percentage 8.23 %

Specialty other Frequency 11 Percentage 6.47 %

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

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. 32665

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

CPT Code:32674 Tracking Number II21

Original Specialty Recommended RVU: **4.53**Presented Recommended RVU: **4.53**

Global Period: ZZZ

RUC Recommended RVU: **4.12**

CPT Descriptor: Thoracoscopy, surgical; with mediastinal and regional lymphadenectomy (List separately in addition to code for primary procedure)

(On the right, mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament)

(On the left, mediastinal lymph nodes include the aortopulmonary window, subcarinal, paraesophageal, and inferior pulmonary ligament).

(Report 32674 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32505, 32503, 32504, 32666, 32667, 32669, 32663, 32670, 32671)

(To report mediastinal and regional lymphadenectomy via thoracotomy, use 38746)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 59-year-old male who undergoes a thoracoscopic right upper lobectomy (separately reported) for a clinical stage I adenocarcinoma. Clinical guidelines indicate the need for a complete thoracic regional and mediastinal lymphadenectomy. Mediastinal lymph nodes are not included within the proximity of the lobectomy specimen. Mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament. The presence of tumor in any lymph nodes in the mediastinum signifies a significantly worse prognosis and indicates the need for postoperative adjuvant therapy.

For this procedure consider only the work of the thoracoscopic lymphadenectomy as defined above. This is an add-on service.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: There is no additional pre-service work

Description of Intra-Service Work: In the ipsilateral chest thoracoscopically dissect and remove regional and mediastinal lymph nodes. On the right this includes the separate removal and labeling of lymph nodes from the following locations: paratracheal, subcarinal, inferior pulmonary ligament, paraesophageal, and hilar.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD					
Specialty(s):	The Society of Thoracic Surgeons					
CPT Code:	32674					
Sample Size:	300	Resp N:	44	Response: 14.6 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	8.00	25.00	36.00	85.00
Survey RVW:		1.50	4.53	6.23	8.00	21.00
Pre-Service Evaluation Time:				8.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		15.00	28.00	30.00	46.00	90.00
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:	32674	Recommended Physician Work RVU: 4.12		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		30.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32501	ZZZ	4.68	RUC Time

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22525	ZZZ	4.47	RUC Time	13,121

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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
35600	ZZZ	4.94	RUC Time	2,872

CPT Descriptor 2 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33518	ZZZ	7.93	RUC Time

CPT Descriptor Coronary artery bypass, using venous graft(s) and arterial graft(s); 2 venous grafts (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: 9 % of respondents: 20.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 32674	<u>Key Reference CPT Code:</u> 32501	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	25.00	
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	25.00
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	2.85	2.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.21	2.68
Urgency of medical decision making	2.97	2.71

Technical Skill/Physical Effort (Mean)

Technical skill required	3.65	3.06
Physical effort required	3.29	2.62

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.32	2.97
Outcome depends on the skill and judgment of physician	3.50	3.09
Estimated risk of malpractice suit with poor outcome	2.71	2.65

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.97	2.62
Intra-Service intensity/complexity	3.47	2.94
Post-Service intensity/complexity	2.62	2.59

Additional Rationale and Comments

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

A survey was conducted with 44 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 25 times for the surveyed code. The vignette was

felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time 30 minutes.

We are recommending a work RVU of 4.53 for this code, which is the 25th percentile value of the survey. This value is supported by the intensity and complexity measures compared to the key reference service, and places the value of this code in appropriate rank order within the family.

Compared to the key reference code 32501, the expert panel felt 32674 took longer and had somewhat less intensity.

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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 38746

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Sometimes

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 4935

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 4164 Percentage 84.37 %

Specialty general surgery Frequency 475 Percentage 9.62 %

Specialty other Frequency 296 Percentage 5.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,702
 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization for the existing open code 38746 is 12,699. It is estimated that 30% of the procedures that are currently reported using the open code will now be reported using the new code 32674.

Specialty cardiothoracic surgery Frequency 3123 Percentage 84.35 %

Specialty general surgery Frequency 357 Percentage 9.64 %

Specialty other Frequency 222 Percentage 5.99 %

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

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. 32501

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

CPT Code:38746 Tracking Number II22

Original Specialty Recommended RVU: **4.49**Presented Recommended RVU: **4.49**

Global Period: ZZZ

RUC Recommended RVU: **4.12**

CPT Descriptor: Thoracic lymphadenectomy by thoracotomy, mediastinal and regional lymphadenectomy, including mediastinal and peritracheal nodes (List separately in addition to code for primary procedure)

(On the right, mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament)

(On the left, mediastinal lymph nodes include the aortopulmonary window, subcarinal, paraesophageal, and inferior pulmonary ligament).

(Report 38746 in conjunction with 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 3250X, 32503, 32504)

(To report mediastinal and regional lymphadenectomy via thoracoscopy (VATS), see 32674)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female has a right lower lobectomy by thoracotomy (separately reported) for a clinical stage I adenocarcinoma. Clinical guidelines indicate the need for a complete thoracic regional and mediastinal lymphadenectomy. Mediastinal lymph nodes include the paratracheal, subcarinal, paraesophageal, and inferior pulmonary ligament. The presence of tumor in any lymph nodes in the mediastinum signifies a significantly worse prognosis and indicates the need for postoperative adjuvant therapy.

For this procedure consider only the work of the open lymphadenectomy as defined above. This is an add-on service.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: There is no additional pre-service work

Description of Intra-Service Work: In the ipsilateral open chest dissect and remove regional and mediastinal lymph nodes. On the right this includes the separate removal and labeling of lymph nodes from the following locations: paratracheal, subcarinal, inferior pulmonary ligament, paraesophageal, and hilar.

Description of Post-Service Work: There is no additional post-service work

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	James M. Levett, MD; Keith S. Naunheim; MD; Cameron D. Wright, MD; Francis C. Nichols, MD				
Specialty(s):	The Society of Thoracic Surgeons				
CPT Code:	38746				
Sample Size:	300	Resp N:	44	Response: 14.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	8.00	15.00	26.00
Survey RVW:		1.32	4.49	6.00	7.88
Pre-Service Evaluation Time:				5.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		10.00	20.00	30.00	40.00
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
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:	38746	Recommended Physician Work RVU: 4.12		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		30.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32501	ZZZ	4.68	RUC Time

CPT Descriptor Resection and repair of portion of bronchus (bronchoplasty) when performed at time of lobectomy or segmentectomy (List separately in addition to code for primary procedure)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
22525	ZZZ	4.47	RUC Time	13,121

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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
35600	ZZZ	4.94	RUC Time	2,872

CPT Descriptor 2 Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure (List separately in addition to code for primary procedure)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33572	ZZZ	6.81	RUC Time

CPT Descriptor Harvest of femoropopliteal vein, 1 segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (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: 8 % of respondents: 18.1 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 38746	<u>Key Reference CPT Code:</u> 32501	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	25.00	
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	25.00
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	3.13	3.13
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.25
Urgency of medical decision making	3.38	3.50

Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.50
Physical effort required	3.25	3.13

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.25	3.38
Outcome depends on the skill and judgment of physician	3.50	3.50
Estimated risk of malpractice suit with poor outcome	3.00	3.13

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.25	3.25
Intra-Service intensity/complexity	3.25	3.63
Post-Service intensity/complexity	3.38	3.13

Additional Rationale and Comments

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

A survey was conducted with 44 respondents. 32501 was selected as the Key Reference Service, and was performed 0 times annually by the respondents, compared to 15 times for the surveyed code. The vignette was

felt to be typical by 100% of the respondents, and the procedure was typically performed as an inpatient. An expert panel reviewed the survey results.

The survey median intraservice time 30 minutes.

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.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 38746

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 cardiothoracic surgery How often? Commonly

Specialty general surgery How often? Commonly

Specialty other How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 11993

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The national frequency is estimated by increasing the Medicare frequency by 1/3.

Specialty cardiothoracic surgery Frequency 10119 Percentage 84.37 %

Specialty general surgery Frequency 1155 Percentage 9.63 %

Specialty other Frequency 719 Percentage 5.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,997

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 utilization for the existing open code 38746 is 12,699. It is estimated that 70% will remain in 38746.

Specialty cardiothoracic surgery Frequency 7590 Percentage 84.36 %

Specialty general surgery Frequency 866 Percentage 9.62 %

Specialty other Frequency 541 Percentage 6.01 %

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 38746

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 Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

Diagnostic Throacoscopy Codes

- 32601 Thoracoscopy, diagnostic, (separate procedure); lung, pericardial sac, mediastinal or pleural space, without biopsy
- 32607 Thoracoscopy; with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
- 32608 Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
- 32609 Thoracoscopy; with biopsy(ies) of pleura

Thoracotomy Codes

- 32096 Thoracotomy, with diagnostic biopsy(ies) of lung infiltrate(s) (eg, wedge, incisional), unilateral
- 32097 Thoracotomy, with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral
- 32098 Thoracotomy, with biopsy(ies) of pleura
- 32505 Thoracotomy; with therapeutic wedge resection (eg, mass, nodule), initial
- 32100 Thoracotomy; with exploration

Surgical Thoracoscopy Codes

- 32666 Thoracoscopy, surgical; with therapeutic wedge resection (eg, mass, nodule), initial unilateral
- 32669 Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)
- 32663 Thoracoscopy, surgical; with lobectomy (single lobe)
- 32670 Thoracoscopy, surgical; with removal of two lobes (bilobectomy)
- 32671 Thoracoscopy, surgical; with removal of lung (pneumonectomy)
- 32672 Thoracoscopy, surgical; with excision/resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed
- 32673 Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral

Global Period: 090

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 cardiothoracic surgeons was used to develop the Practice Expense recommendations

The panel reviewed the RUC standard values, discussed current practice patterns and standards and determined that current RUC standard values for 90 day global procedures were appropriate.

For the 0 day globals, need the following: Although 32601, 32607, 32608, and 32609 are currently defined as 0 day globals, these are anomalous codes. These patients all undergo operative procedures in the Operating Room under general anaesthesia so all scheduling, coordinating, patient education/obtain consent and follow-up office

CPT Code: 32601, 32607, 32608, 32609
AMA/Specialty Society RVS Update Committee Recommendation

activities that are routine for other operative procedures (e.g., 32095; “Open thoracotomy for biopsy of lung or pleura”) must be carried out for these procedures. These activities are delineated below in the preservice section. It is relevant to note that when we surveyed our members for physician work estimation, they reported that this procedure was typically associated with 2 to 3 hospital days. We realize that E&M codes can be billed for office activities and hospital visits but this office clinical work can only be captured by including it in the value of the code.

If you have provide 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:

Thoracotomy codes (32096, 32097, 32098, 32505, 32100)

The clinical staff fills out the pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility. They will also coordinate with anesthesia, and the operating room. The clinical staff will educate the patient on what they need to do to prepare for surgery. The staff ensures the patient and family fully understand the procedure and the recovery afterwards and obtain the operative consent. They make follow-up phone calls to the patient and the office of referring physicians and call in needed prescriptions.

Diagnostic thoracoscopy (32601, 3260X, 3260X1, 3260X2) and surgical thoracoscopy codes (32666, 32669, 32663, 32670, 32671, 32672 32673)

The clinical staff fills out the pre-service diagnostic and referral forms. They call the hospital to schedule space and equipment needed in the facility. They will also coordinate with anesthesia, and the operating room. The operating room coordinating requires ensuring the needed video equipment and minimally invasive instrumentation are available and present. The clinical staff will educate the patient on what they need to do to prepare for surgery. The staff ensures the patient and family fully understand the procedure and the recovery afterwards and obtain the operative consent. They make follow-up phone calls to the patient and the office of referring physicians and call in needed prescriptions.

Intra-Service Clinical Labor Activities:

Thoracotomy codes (32096, 32097, 32098, 32505, 32100)

Surgical thoracoscopy codes (32666, 32669, 32663, 32670, 32671, 32672 32673)

Office staff participate in discharge day management activities including coordination of home health services, phoning in prescriptions, reviewing and emphasizing follow-up instructions, notifying the office of the referring physician, coordinating follow-up office visits and answering patient and family questions.

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			THORACOSCOPY, DIAGNOSTIC			
2				II8	II9	II10	II11
3	Meeting Date: April 2011			32601	32607	32608	32609
4	Specialty: STS			Thoracoscopy, diagnostic, (separate procedure); lungs,	Thoracoscopy, diagnostic; with biopsy(ies) of lung infiltrate	Thoracoscopy, diagnostic; with biopsy(ies) of lung	Thoracoscopy, diagnostic; with biopsy(ies) of pleura
5	LOCATION	Code	Staff Type	FAC	FAC	FAC	FAC
6	GLOBAL PERIOD			000	000	000	000
7	TOTAL CLINICAL LABOR TIME	L051A	RN	30	30	30	30
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	30	30	30	30
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0
10	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	0	0	0	0
11	PRE-SERVICE						
12	Start: Following visit when decision for surgery or procedure made						
13	Complete pre-service diagnostic & referral forms	L051A	RN	5	5	5	5
14	Coordinate pre-surgery services	L051A	RN	10	10	10	10
15	Schedule space and equipment in facility	L051A	RN	5	5	5	5
16	Provide pre-service education/obtain consent	L051A	RN	7	7	7	7
17	Follow-up phone calls & prescriptions	L051A	RN	3	3	3	3
19	End:When patient enters office/facility for surgery/procedure						
20	SERVICE PERIOD						
21	Start: When patient enters site for procedure: Services Prior to Procedure						
39	Discharge day management	L051A	RN				
41	End: Patient leaves office						
42	POST-SERVICE Period						
43	Start: Patient leaves office/facility						
45	<i>Office visits:</i>						
46	<i>List Number and Level of Office Visits</i>						
47	99211		16				
48	99212		27				
49	99213		36				
50	99214		53				
51	99215		63				
52	Other						
53	Total Office Visit Time	L051A	RN	0	0	0	0
54	Other Total:						
55	End: with last office visit before end of global period						
56	MEDICAL SUPPLIES						
57	pack, minimum multi-specialty visit	SA048	pack				
58	pack, post-op incision care (suture & staple)	SA053	pack				
59	Equipment						
60	table, power	EF031					
61	light, surgical	EF014					

	A	B	C	H	I	J	K	L	M	N
1	AMA/Specialty Society RVS Update Committee Recommendation			THORACOSCOPY, SURGICAL						
2				II12	II15	IY16	II17	II18	II19	II20
3	Meeting Date: April 2011 Specialty: STS			32666	32669	32663	32670	32671	32672	32673
4				Thoracoscopy, surgical; with diagnostic or therapeutic wedge	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)	Thoracoscopy, surgical; with lobectomy (single lobe)	Thoracoscopy, surgical; with removal of two lobes (bilobectomy)	Thoracoscopy, surgical; with removal of lung, pneumonectomy	Thoracoscopy, surgical; with excision/resection-plication for	Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral
5	LOCATION	Code	Staff Type	FAC	FAC	FAC	FAC	FAC	FAC	FAC
6	GLOBAL PERIOD			090	090	090	090	090	090	090
7	TOTAL CLINICAL LABOR TIME	L051A	RN	135	135	135	135	135	135	135
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	60	60	60	60	60	60	60
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	12	12	12	12	12	12	12
10	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	63	63	63	63	63	63	63
11	PRE-SERVICE									
12	Start: Following visit when decision for surgery or procedure made									
13	Complete pre-service diagnostic & referral forms	L051A	RN	5	5	5	5	5	5	5
14	Coordinate pre-surgery services	L051A	RN	20	20	20	20	20	20	20
15	Schedule space and equipment in facility	L051A	RN	8	8	8	8	8	8	8
16	Provide pre-service education/obtain consent	L051A	RN	20	20	20	20	20	20	20
17	Follow-up phone calls & prescriptions	L051A	RN	7	7	7	7	7	7	7
19	End: When patient enters office/facility for surgery/procedure									
20	SERVICE PERIOD									
21	Start: When patient enters site for procedure: Services Prior to Procedure									
39	Discharge day management	L051A	RN	12	12	12	12	12	12	12
41	End: Patient leaves office									
42	POST-SERVICE Period									
43	Start: Patient leaves office/facility									
45	Office visits:									
46	List Number and Level of Office Visits									
47	99211	16 minutes	16							
48	99212	27 minutes	27	1	1	1	1	1	1	1
49	99213	36 minutes	36	1	1	1	1	1	1	1
50	99214	53 minutes	53							
51	99215	63 minutes	63							
52	Other									
53	Total Office Visit Time	L051A	RN	63	63	63	63	63	63	63
54	Other Total:									
55	End: with last office visit before end of global period									
56	MEDICAL SUPPLIES									
57	pack, minimum multi-specialty visit	SA048	pack	2	2	2	2	2	2	2
58	pack, post-op incision care (suture & staple)	SA053	pack	1	1	1	1	1	1	1
59	Equipment									
60	table, power	EF031		63	63	63	63	63	63	63
61	light, surgical	EF014		63	63	63	63	63	63	63

	A	B	C	O	P	Q	R	S	T	U	V	W	X	Y
1	AMA/Specialty Society RVS Update Committee Recommendation			THORACOTOMY					ADD-ON					
2				II1	II2	II3	II4	II5	II6	II7	II13	II14	II21	II22
3	Meeting Date: April 2011 Specialty: STS			32096	32097	32098	32100	32505	32506	32507	32667	32668	32674	38746
4				Thoracotomy, with biopsy(ies) of lung infiltrate(s)	Thoracotomy, with biopsy(ies) of lung nodule(s) or	Thoracotomy, with biopsy(ies) of pleura	Thoracotomy; with exploration	Thoracotomy; with diagnostic or therapeutic wedge	Thoracotomy; with diagnostic or therapeutic wedge resection	Thoracotomy; with diagnostic wedge resection	Thoracoscopy, surgical; with diagnostic or therapeutic wedge	Thoracoscopy, surgical; with diagnostic wedge resection	Thoracoscopy, surgical; with mediastinal and regional lymphadenect	Thoracic lymphadenectomy by thoracotomy, mediastinal
5	LOCATION	Code	Staff Type	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC
6	GLOBAL PERIOD			090	090	090	090	090	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
7	TOTAL CLINICAL LABOR TIME	L051A	RN	108	108	108	108	135	0	0	0	0	0	0
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	60	60	60	60	60	0	0	0	0	0	0
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	12	12	12	12	12	0	0	0	0	0	0
10	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	36	36	36	36	63	0	0	0	0	0	0
11	PRE-SERVICE													
12	Start: Following visit when decision for surgery or procedure made													
13	Complete pre-service diagnostic & referral forms	L051A	RN	5	5	5	5	5	0	0	0	0	0	0
14	Coordinate pre-surgery services	L051A	RN	20	20	20	20	20	0	0	0	0	0	0
15	Schedule space and equipment in facility	L051A	RN	8	8	8	8	8	0	0	0	0	0	0
16	Provide pre-service education/obtain consent	L051A	RN	20	20	20	20	20	0	0	0	0	0	0
17	Follow-up phone calls & prescriptions	L051A	RN	7	7	7	7	7	0	0	0	0	0	0
19	End:When patient enters office/facility for surgery/procedure													
20	SERVICE PERIOD													
21	Start: When patient enters site for procedure: Services Prior to Procedure													
39	Discharge day management	L051A	RN	12	12	12	12	12						
41	End: Patient leaves office													
42	POST-SERVICE Period													
43	Start: Patient leaves office/facility													
45	Office visits:													
46	List Number and Level of Office Visits													
47	99211	16 minutes	16											
48	99212	27 minutes	27					1						
49	99213	36 minutes	36	1	1	1	1	1						
50	99214	53 minutes	53											
51	99215	63 minutes	63											
52	Other													
53	Total Office Visit Time	L051A	RN	36	36	36	36	63	0	0	0	0	0	0
54	Other Total:													
55	End: with last office visit before end of global period													
56	MEDICAL SUPPLIES													
57	pack, minimum multi-specialty visit	SA048	pack	1	1	1	1	2						
58	pack, post-op incision care (suture & staple)	SA053	pack	1	1	1	1	1						
59	Equipment													
60	table, power	EF031		36	36	36	36	63						
61	light, surgical	EF014		36	36	36	36	63						

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Committee Recommendation			THORACOSCOPY, DIAGNOSTIC			
2				II8	II9	II10	II11
3	Meeting Date: April 2011			32601	32607	32608	32609
4	Specialty: STS			Thoracoscopy, diagnostic, (separate procedure); lungs,	Thoracoscopy, diagnostic; with biopsy(ies) of lung infiltrate	Thoracoscopy, diagnostic; with biopsy(ies) of lung	Thoracoscopy, diagnostic; with biopsy(ies) of pleura
5	LOCATION	Code	Staff Type	FAC	FAC	FAC	FAC
6	GLOBAL PERIOD			000	000	000	000
7	TOTAL CLINICAL LABOR TIME	L051A	RN	60	60	60	60
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	60	60	60	60
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	0	0	0	0
10	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	0	0	0	0
11	PRE-SERVICE						
12	Start: Following visit when decision for surgery or procedure made						
13	Complete pre-service diagnostic & referral forms	L051A	RN	5	5	5	5
14	Coordinate pre-surgery services	L051A	RN	20	20	20	20
15	Schedule space and equipment in facility	L051A	RN	8	8	8	8
16	Provide pre-service education/obtain consent	L051A	RN	20	20	20	20
17	Follow-up phone calls & prescriptions	L051A	RN	7	7	7	7
19	End:When patient enters office/facility for surgery/procedure						
20	SERVICE PERIOD						
21	Start: When patient enters site for procedure: Services Prior to Procedure						
39	Discharge day management	L051A	RN				
41	End: Patient leaves office						
42	POST-SERVICE Period						
43	Start: Patient leaves office/facility						
45	<i>Office visits:</i>						
46	<i>List Number and Level of Office Visits</i>						
47	99211		16 minutes				
48	99212		27 minutes				
49	99213		36 minutes				
50	99214		53 minutes				
51	99215		63 minutes				
52	Other						
53	Total Office Visit Time	L051A	RN	0	0	0	0
54	Other Total:						
55	End: with last office visit before end of global period						
56	MEDICAL SUPPLIES						
57	pack, minimum multi-specialty visit	SA048	pack				
58	pack, post-op incision care (suture & staple)	SA053	pack				
59	Equipment						
60	table, power	EF031					
61	light, surgical	EF014					

	A	B	C	H	I	J	K	L	M	N
1	AMA/Specialty Society RVS Update Committee Recommendation			THORACOSCOPY, SURGICAL						
2				II12	II15	IY16	II17	II18	II19	II20
3	Meeting Date: April 2011 Specialty: STS			32666	32669	32663	32670	32671	32672	32673
4				Thoracoscopy, surgical; with diagnostic or therapeutic wedge	Thoracoscopy, surgical; with removal of a single lung segment (segmentectomy)	Thoracoscopy, surgical; with lobectomy (single lobe)	Thoracoscopy, surgical; with removal of two lobes (bilobectomy)	Thoracoscopy, surgical; with removal of lung, pneumonectomy	Thoracoscopy, surgical; with excision/resection-plication for	Thoracoscopy, surgical; with resection of thymus, unilateral or bilateral
5	LOCATION	Code	Staff Type	FAC	FAC	FAC	FAC	FAC	FAC	FAC
6	GLOBAL PERIOD			090	090	090	090	090	090	090
7	TOTAL CLINICAL LABOR TIME	L051A	RN	135	135	135	135	135	135	135
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	60	60	60	60	60	60	60
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	12	12	12	12	12	12	12
10	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	63	63	63	63	63	63	63
11	PRE-SERVICE									
12	Start: Following visit when decision for surgery or procedure made									
13	Complete pre-service diagnostic & referral forms	L051A	RN	5	5	5	5	5	5	5
14	Coordinate pre-surgery services	L051A	RN	20	20	20	20	20	20	20
15	Schedule space and equipment in facility	L051A	RN	8	8	8	8	8	8	8
16	Provide pre-service education/obtain consent	L051A	RN	20	20	20	20	20	20	20
17	Follow-up phone calls & prescriptions	L051A	RN	7	7	7	7	7	7	7
19	End: When patient enters office/facility for surgery/procedure									
20	SERVICE PERIOD									
21	Start: When patient enters site for procedure: Services Prior to Procedure									
39	Discharge day management	L051A	RN	12	12	12	12	12	12	12
41	End: Patient leaves office									
42	POST-SERVICE Period									
43	Start: Patient leaves office/facility									
45	Office visits:									
46	List Number and Level of Office Visits									
47	99211	16 minutes	16							
48	99212	27 minutes	27	1	1	1	1	1	1	1
49	99213	36 minutes	36	1	1	1	1	1	1	1
50	99214	53 minutes	53							
51	99215	63 minutes	63							
52	Other									
53	Total Office Visit Time	L051A	RN	63	63	63	63	63	63	63
54	Other Total:									
55	End: with last office visit before end of global period									
56	MEDICAL SUPPLIES									
57	pack, minimum multi-specialty visit	SA048	pack	2	2	2	2	2	2	2
58	pack, post-op incision care (suture & staple)	SA053	pack	1	1	1	1	1	1	1
59	Equipment									
60	table, power	EF031		63	63	63	63	63	63	63
61	light, surgical	EF014		63	63	63	63	63	63	63

	A	B	C	O	P	Q	R	S	T	U	V	W	X	Y
1	AMA/Specialty Society RVS Update Committee Recommendation			THORACOTOMY					ADD-ON					
2				II1	II2	II3	II4	II5	II6	II7	II13	II14	II21	II22
3	Meeting Date: April 2011 Specialty: STS			32096	32097	32098	32100	32505	32506	32507	32667	32668	32674	38746
4				Thoracotomy, with biopsy(ies) of lung infiltrate(s)	Thoracotomy, with biopsy(ies) of lung nodule(s) or	Thoracotomy, with biopsy(ies) of pleura	Thoracotomy; with exploration	Thoracotomy; with diagnostic or therapeutic wedge	Thoracotomy; with diagnostic or therapeutic wedge resection	Thoracotomy; with diagnostic wedge resection	Thoracoscopy, surgical; with diagnostic or therapeutic wedge	Thoracoscopy, surgical; with diagnostic wedge resection	Thoracoscopy, surgical; with mediastinal and regional lymphadenect	Thoracic lymphadenectomy by thoracotomy, mediastinal
5	LOCATION	Code	Staff Type	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC	FAC
6	GLOBAL PERIOD			090	090	090	090	090	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ	ZZZ
7	TOTAL CLINICAL LABOR TIME	L051A	RN	108	108	108	108	135	0	0	0	0	0	0
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L051A	RN	60	60	60	60	60	0	0	0	0	0	0
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L051A	RN	12	12	12	12	12	0	0	0	0	0	0
10	TOTAL POST-SERV CLINICAL LABOR TIME	L051A	RN	36	36	36	36	63	0	0	0	0	0	0
11	PRE-SERVICE													
12	Start: Following visit when decision for surgery or procedure made													
13	Complete pre-service diagnostic & referral forms	L051A	RN	5	5	5	5	5	0	0	0	0	0	0
14	Coordinate pre-surgery services	L051A	RN	20	20	20	20	20	0	0	0	0	0	0
15	Schedule space and equipment in facility	L051A	RN	8	8	8	8	8	0	0	0	0	0	0
16	Provide pre-service education/obtain consent	L051A	RN	20	20	20	20	20	0	0	0	0	0	0
17	Follow-up phone calls & prescriptions	L051A	RN	7	7	7	7	7	0	0	0	0	0	0
19	End:When patient enters office/facility for surgery/procedure													
20	SERVICE PERIOD													
21	Start: When patient enters site for procedure: Services Prior to Procedure													
39	Discharge day management	L051A	RN	12	12	12	12	12						
41	End: Patient leaves office													
42	POST-SERVICE Period													
43	Start: Patient leaves office/facility													
45	Office visits:													
46	List Number and Level of Office Visits													
47	99211	16 minutes	16											
48	99212	27 minutes	27					1						
49	99213	36 minutes	36	1	1	1	1	1						
50	99214	53 minutes	53											
51	99215	63 minutes	63											
52	Other													
53	Total Office Visit Time	L051A	RN	36	36	36	36	63	0	0	0	0	0	0
54	Other Total:													
55	End: with last office visit before end of global period													
56	MEDICAL SUPPLIES													
57	pack, minimum multi-specialty visit	SA048	pack	1	1	1	1	2						
58	pack, post-op incision care (suture & staple)	SA053	pack	1	1	1	1	1						
59	Equipment													
60	table, power	EF031		36	36	36	36	63						
61	light, surgical	EF014		36	36	36	36	63						

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment – Codes Reported Together 75% or More Screen

April 2011

Pacemaker or Pacing Cardioverter-Defibrillator

In February 2010, the Pacemaker and Pacing Cardioverter-Defibrillator series of CPT codes (33207, 33208, 33212, 33213, 33240 and 33249) were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These insertion codes were commonly billed with the removal codes (33233, 33241 and 71090) or the device evaluation code (93641). In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. A total of 12 codes were created or significantly revised, mandating a RUC survey in April 2011.

The RUC and specialties determined that only 1 level three office visit (99213) and a half discharge day management service are typical for the wound care management for each of the services in this family. Additionally, the RUC discussed the problematic survey data and found consistency in the relationship between the physician time and work values within the family of insertion only codes (33212, 33213, 33221, 33240, 33230 and 33231). However, for the removal and replacement series of codes (33227, 33228, 33229, 33262, 33263, 33264) the survey data was inconsistent in both physician time and work value. Given this understanding, the RUC and specialties agreed that the recommended work RVUs for these services be interim and a comprehensive RUC survey be presented at the September 2011 RUC Meeting.

Pacemaker Services

33212 Insertion of pacemaker pulse generator only with existing; single lead

The RUC reviewed the survey results from 36 cardiologists for CPT code 33212. The RUC and specialties agreed that the post-service time should be lowered from the survey median time of 27.5 minutes to 20 minutes to align itself with the other pacemaker family of services. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 5.39 is a reasonable interim value for this service. To further justify this value, the RUC reviewed code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 5.34) and agreed that the physician work of this service is analogous to the work of 33212 and should be valued similarly due to similar intra-service time, 45 minutes and 50 minutes, respectively, and intensity and complexity. **The RUC recommends an interim work RVU of 5.39 for CPT code 33212.**

33213 *Insertion of pacemaker pulse generator only with existing; dual leads*

The RUC reviewed the survey results from 32 cardiologists for CPT code 33213. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 5.61 is a reasonable interim value for this service. To further justify this value, the RUC compared this service to the single lead insertion base code 33212 and agreed that there is more physician work involved in 33213 given the greater total time, 50 minutes, compared to 33212 with 45 minutes. Also, the RUC compared the surveyed code to CPT code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 5.34) to 33213 and agreed that the surveyed code is a more intense and complex procedure than the reference code. **The RUC recommends an interim work RVU of 5.61 for CPT code 33213.**

33221 *Insertion of pacemaker pulse generator only with existing; multiple leads*

The RUC reviewed the survey results from 33 cardiologists for CPT code 33221. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 6.00 is a reasonable interim value for this service. To further justify this value, the RUC compared this service to the dual lead insertion base code 33213 and agreed that there is more physician work involved in 33221 given the greater total time, 60 minutes, compared to 33212 with 50 minutes. Also, the RUC compared the surveyed code to the reference code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 5.34) and agreed that the physician work between the services are similar and the surveyed code should be valued higher due to greater total time, 60 minutes compared to 50 minutes, and intensity. **The RUC recommends an interim work RVU of 6.00 for CPT code 33221.**

33227 *Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system*

The RUC reviewed the survey results from 39 cardiologists for CPT code 33227. The RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33227, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33212, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33212 and 33227 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the services, was applied to code 33212 to obtain the work value of 4.85 for 33227. To further justify a work RVU of 4.85, the RUC compared the surveyed service to CPT code 49441 *Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 4.77 and total time= 133) and agreed that the two services, with identical intra time, 45 minutes, and analogous intensity, should be valued similarly. **The RUC recommends an interim work RVU of 4.85 for CPT code 33227.**

33228 *Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system*

The RUC reviewed the survey results from 36 cardiologists for CPT code 33228. The RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33228, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33213, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33213 and 33228 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given

the relationship in physician work and intensity between the services, was applied to code 33213 to obtain the work value of 5.05 for 33228. To further justify a work RVU of 5.05, the RUC compared the surveyed service to the single lead system code, 33227, and agreed that the dual lead system should be valued greater due to greater intensity and complexity. Additionally, the RUC compared the surveyed code to CPT code 49441 *Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 4.77 and total time= 133) and the surveyed code should be valued higher due to greater total time compared to the reference code, 148 minutes and 133 minutes, respectively. **The RUC recommends an interim work RVU of 5.05 for CPT code 33228.**

33229 Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system

The RUC reviewed the survey results from 31 cardiologists for CPT code 33229. The RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33229, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33221, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33221 and 33229 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the services, was applied to code 33221 to obtain the work value of 5.40 for 33229. To further justify a work RVU of 5.40, the RUC compared the surveyed service to the dual lead system code, 33228, and agreed that the dual lead system should be valued greater due to greater intensity and intra-service time, 50 minutes compared to 45 minutes. Additionally, the RUC compared the surveyed code to CPT code 36571 *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older* (work RVU= 5.34 and total time= 140) and agreed that the two services, with identical intra time, 50 minutes, and analogous intensity, should be valued similarly. **The RUC recommends an interim work RVU of 5.40 for CPT code 33229.**

Cardio-defibrillator Pulse Generator Services

33240 Insertion of pacing cardioverter-defibrillator pulse generator only with existing; single lead

The RUC reviewed the survey results from 30 cardiologists for CPT code 33240. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 7.00 is a reasonable interim value for this service. To ensure the value is relative across the family of services, the RUC compared 33240 to the pacemaker insertion-only, single lead code, 33212, and noted that 33240 should be valued higher because defibrillators are larger devices compared to pacemakers, requiring a larger pocket dissection and greater risk of bleeding and tissue injury. Also, patients receiving a defibrillator have either prior lethal arrhythmia or severe heart failure and are sicker than patients receiving a pacemaker. For additional justification, the RUC compared the surveyed code to CPT code 49325 *Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed* (work RVU= 6.82) and agreed that the two services have identical intra-service time, 60 minutes, with analogous intensity and should be valued similarly. **The RUC recommends an interim work RVU of 7.00 for CPT code 33240.**

33230 *Insertion of pacing cardioverter-defibrillator pulse generator only with existing; dual leads*

The RUC reviewed the survey results for CPT code 33230. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 7.00 is a reasonable interim value of the physician work involved in this service. The RUC agreed that the insertion of a dual lead pulse generator is slightly more intense than the placement of a single lead defibrillator, but the intensity was not captured in the survey. The RUC compared 33230 to the base code 33240 and noted that both have identical median survey intra-service time, 60 minutes, and identical 25th percentile work values at 7.00 work RVUs. For additional justification, the RUC compared the surveyed code to CPT code 49325 *Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed* (work RVU= 6.82) and agreed that the two services have identical intra-service time, 60 minutes, with analogous intensity and should be valued similarly. **The RUC recommends an interim work RVU of 7.00 for CPT code 33230.**

33231 *Insertion of pacing cardioverter-defibrillator pulse generator only with existing; multiple leads*

The RUC reviewed the survey results for CPT code 33231. The RUC reviewed the survey work values and agreed that the 25th percentile work RVU of 7.25 is a reasonable interim value for the physician work involved in this service. The RUC compared 33231 to the dual lead defibrillator code, 33230, and agreed that while the times are identical, the insertion of a multiple lead generator is a more intense procedure compared to the insertion of a single lead defibrillator. For additional justification, the RUC compared the surveyed code to CPT code 63650 *Percutaneous implantation of neurostimulator electrode array, epidural* (work RVU= 7.20) and agreed that the two service have identical intra-service time, 60 minutes, with analogous intensity and should be valued similarly. **The RUC recommends an interim work RVU of 7.25 for CPT code 33231.**

33262 *Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system*

The RUC reviewed the survey results from 39 cardiologists for CPT code 33262. The RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33262, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33240, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33240 and 33262 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the services, was applied to code 33240 to obtain a work value of 6.30 for 33262. To further justify a work RVU of 6.30, the RUC compared the surveyed service to CPT code 36560 *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age* (work RVU= 6.29) and agreed that the services have identical intra-service time, 45 minutes, with analogous intensity and should be valued similarly. **The RUC recommends an interim work RVU of 6.30 for CPT code 33262.**

33263 Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system

The RUC reviewed the survey results from 33 cardiologists for CPT code 33263. RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33263, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33230, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33230 and 33263 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the services, was applied to code 33230 to obtain a work value of 6.30 for 33263. To justify a work RVU of 6.30, the RUC compared 33263 to the single lead defibrillator base code 33262 and agreed that while the intra time is greater for the dual lead system, the intensity relationship is comparable throughout the family and should be maintained. Additionally, the RUC compared the surveyed code to CPT code 62362 *Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming* (work RVU= 6.10) and agreed that the services, with identical intra-service time of 60 minutes, and analogous work and intensity, should be valued similarly. **The RUC recommends an interim work RVU of 6.30 for CPT code 33263.**

33264 Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system

The RUC reviewed the survey results from 37 cardiologists for CPT code 33264. The RUC reviewed the survey work values and agreed that the respondents overestimated the work involved in this procedure. The RUC, based on expert opinion, agreed 33264, a removal and replacement service, is likely to have a final work value lower than the value for the analogous insertion-only code, 33231, because a mature pocket is available when a unit is removed and replaced, whereas a pocket has to be created when a unit is initially inserted. Additionally, the RUC concurred that the relationship between 33231 and 33264 is uniform, along with the entire family. Thus, a 10% decrement, deemed reasonable on an interim basis given the relationship in physician work and intensity between the services, was applied to code 33231 to obtain a work value of 6.53 for 33264. To justify a work RVU of 6.53, the RUC compared 33264 to the dual lead generator base code 33263 and agreed that with the increase in intra-service time, 65 minutes and 60 minutes, respectively, for the multiple lead system, 33264 should be valued slightly higher than 33231. Additionally, the RUC compared the surveyed code to CPT code 62362 *Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming* (work RVU= 6.10) and agreed while the services are similar in intensity and physician work, the surveyed code should be valued higher due to greater intra-service time, 65 minutes compared to 60 minutes for the reference code. **The RUC recommends an interim work RVU of 6.53 for CPT code 33264.**

Work Neutrality

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

Practice Expense

The RUC accepted the direct practice expense inputs recommended by the specialty for these procedures performed in the facility setting.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Surgery Cardiovascular System Heart and Pericardium Pacemaker or Pacing Cardioverter-Defibrillator</p> <p>A pacemaker system includes a pulse generator containing electronics, a battery, and one or more electrodes (leads). Pulse generators are placed in a subcutaneous "pocket" created in either a subclavicular site or underneath the abdominal muscles just below the ribcage. Electrodes may be inserted through a vein (transvenous) or they may be placed on the surface of the heart (epicardial). The epicardial location of electrodes requires a thoracotomy for electrode insertion.</p> <p>A single chamber pacemaker system includes a pulse generator and one electrode inserted in either the atrium or ventricle. A dual chamber pacemaker system includes a pulse generator and one electrode inserted in the right atrium and one electrode inserted in the right ventricle. In certain circumstances, an additional electrode may be required to achieve pacing of the left ventricle (bi-ventricular pacing). In this event, transvenous (cardiac vein) placement of the electrode should be separately reported using code 33224 or 33225. Epicardial placement of the electrode should be separately reported using 33202-33203.</p> <p>Like a pacemaker system, a pacing cardioverter-defibrillator (<u>ICD</u>) system includes a pulse generator and electrodes, although pacing cardioverter-defibrillators may require multiple leads, even when only a single chamber is being paced. A pacing cardioverter-defibrillator system may be inserted in a single chamber (pacing in the ventricle) or in dual chambers (pacing in atrium and ventricle). These devices use a combination of antitachycardia pacing, low-energy cardioversion or defibrillating shocks to treat ventricular tachycardia or ventricular fibrillation.</p> <p>Pacing cardioverter-defibrillator pulse generators may be implanted in a subcutaneous infraclavicular pocket or in an abdominal pocket. Removal of a pacing cardioverter-defibrillator pulse generator requires opening of the existing subcutaneous pocket and disconnection of the pulse generator from its electrode(s). A thoracotomy (or laparotomy in the case of abdominally placed pulse generators) is not required to remove the pulse generator.</p> <p>The electrodes (leads) of a pacing cardioverter-defibrillator system are positioned in the heart via the venous system (transvenously), in most circumstances. In certain circumstances, an additional electrode may be required to achieve pacing of the left ventricle (bi-ventricular pacing). In this event, transvenous (cardiac vein) placement of the electrode should be separately reported using code 33224 or 33225. Epicardial placement</p>				

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p>of the electrode should be separately reported using 33202-33203.</p> <p>Electrode positioning on the epicardial surface of the heart requires a thoracotomy, or thoracoscopic placement of the leads. Removal of electrode(s) may first be attempted by transvenous extraction (code33234, 33235, or 33244). However, if transvenous extraction is unsuccessful, a thoracotomy may be required to remove the electrodes (code33238 or 33243). Use codes33212, 33213, 33221, 3324033230, 33231, as appropriate in addition to the thoracotomy or endoscopic epicardial lead placement codes to report the insertion of the generator if done by the same physician during the same session. (33202 or 33203) to report the insertion of the generator if done by the same physician during the same session.</p> <p>When the “battery” of a pacemaker or pacing cardioverter-defibrillator is changed, it is actually the pulse generator that is changed. <u>Removal of pacemaker or pacing cardioverter-defibrillator pulse generator only is reported with 33233 or 33241. Removal of a pacemaker or pacing cardioverter-defibrillator pulse generator with insertion of a new pulse generator without any replacement or insertion of a lead(s) is reported with 33227-33229 and 33262-33264. Replacement</u>Insertion of a new pulse generator, when existing leads are already in place and when no prior pulse generator should beis removed, is reported with 33212, 33213, 33221, 33240, 33230, 33231. When a codepulse generator insertion involves the insertion or replacement of one or more lead(s), use the system codes 33206-33208 for pacemaker or 33249 for removalpacing cardioverter-defibrillator. <u>Removal of the</u>a pulse generator and another code for insertion(33233 or 33241) or extraction of transvenous leads (33234, 33235 or 33244) should be reported separately. An exception involves a pacemaker upgrade from single to dual system which includes removal of pulse generator, replacement of new pulse generator, and insertion of new lead, reported with 33214.</p> <p>Repositioning of a pacemaker electrode, pacing cardioverter-defibrillator electrode(s), or a left ventricular pacing electrode is reported using 33215 or 33226, as appropriate. Replacement of a pacemaker electrode, pacing cardioverter-defibrillator electrode(s), or a left ventricular pacing electrode is reported using 33206-33208, 33210-33213, or 33224, as appropriate.</p> <p><u>The pacemaker and pacing cardioverter-defibrillator device evaluation codes 93279-93299 may not be reported in conjunction with pulse generator and lead insertion or revision codes 33206-33249. Defibrillator threshold testing (DFT) during pacing cardioverter-defibrillator insertion or replacement may be separately reported using 93640, 93641.</u></p> <p><u>Radiological supervision and interpretation related to the pacemaker or pacing cardioverter-defibrillator procedure is included in 33206-33249. To report fluoroscopic guidance for diagnostic lead evaluation without lead insertion, replacement, or revision procedures, use 76000.</u></p> <p><u>The following definitions apply to 33206-33249.</u></p>				

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<i>Single lead:</i> a pacemaker or pacing cardioverter-defibrillator with pacing and sensing function in only one chamber of the heart.				
<i>Dual lead:</i> a pacemaker or pacing cardioverter-defibrillator with pacing and sensing function in only two chambers of the heart.				
<i>Multiple lead:</i> a pacemaker or pacing cardioverter-defibrillator with pacing and sensing function in three or more chambers of the heart.				
33202		Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)	090	13.20 (No Change)
33203		endoscopic approach (eg, thoracoscopy, pericardioscopy) (When epicardial lead placement is performed by the same physician at the same session as with insertion of the generator, report 33202, 33203 in conjunction with 33212, 33213, 33221, 33240, 33230, 33231 as appropriate)	090	13.97 (No Change)
E ©33206		Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	090	7.39 (No Change)
E ©33207		ventricular	090	8.05 (No Change)
E ©33208		atrial and ventricular (Codes 33206-33208 include subcutaneous insertion of the pulse generator and transvenous placement of electrode[s]) (For removal and replacement of pacemaker pulse generator and transvenous electrode(s), use 33233 in conjunction with either 33234 or 33235 and 33206-33208) (Do not report 33206-33208 in conjunction with 33227-33229)	090	8.77 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
◎ ▲ 33212	U1	Insertion or replacement of pacemaker pulse generator only; <u>with existing single lead chamber, atrial or ventricular</u>	090	5.39 (Interim)
◎ ▲ 33213	U2	<u>with existing dual leads chamber</u>	090	5.61 (Interim)
◎ ● 33221	U3	with existing multiple leads <u>(Do not report 33212, 33213, 33221 in conjunction with 33233 for removal and replacement of the pacemaker pulse generator. Use 33227-33229, as appropriate, when pulse generator replacement is indicated)</u> <u>(When epicardial lead placement is performed with insertion of generator, report 33202, 33203 in conjunction with 33212, 33213, 33221)</u>	090	6.00 (Interim)
E ◎ 33214		Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator) <u>(Do not report 33214 in conjunction with 33227-33229)</u> <u>(When epicardial electrode placement is performed, report 33214 in conjunction with 33202, 33203)</u>	090	7.84 (No Change)
E ◎ 33218		Repair of single transvenous electrode for a single chamber , permanent pacemaker or single chamber pacing cardioverter-defibrillator <u>(For atrial or ventricular repair of single chamber repair of pacemaker permanent pacemaker or pacing cardioverter-defibrillator electrode[s] with replacement of pulse generator, see 3321233227-33229 or 3321333262-33264 and 33218 or 33220)</u>	090	6.07 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
E ©33220		Repair of 2 transvenous electrodes for a dual chamber permanent pacemaker or dual chamber pacing cardioverter-defibrillator (For repair of 2 transvenous electrodes for permanent pacemaker or pacing cardioverter-defibrillator with replacement of pulse generator, use 33228, 33229 or 33263, 33264 and 33220)	090	6.15 (No Change)
E 33224		Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of <u>existing</u> generator) (When epicardial electrode placement is performed, report 33224 in conjunction with 33202, 33203)	000	9.04 (No Change)
E 33225		Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system) (List separately in addition to code for primary procedure) (Use 33225 in conjunction with 33206, <u>33207</u> , 33208, 33212, 33213, <u>33221</u> , 33214, 33216, 33217, 33222, 33233, <u>33234</u> , 33235, 33240, <u>33230</u> , <u>33231</u> , 33249)	000	8.33 (No Change)
E ©33233		Removal of permanent pacemaker pulse generator <u>only</u>	090	3.39 (No Change)
#©●33227	U4	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	090	4.85 (Interim)
#©●33228	U5	dual lead system	090	5.05 (Interim)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
#◎● 33229	U6	multiple lead system (Do not report 33227-33229 in conjunction with 33233) <u>(For removal and replacement of pacemaker pulse generator and transvenous electrode(s), use 33233 in conjunction with either 33234 or 33235 and 33206-33208)</u>	090	5.40 (Interim)
◎▲ 33240	U7	Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator <u>only with; existing single lead</u> <i>(Use 33240, as appropriate, in addition to the epicardial lead placement codes to report the insertion of the generator when done by the same physician during the same session)</i>	090	7.00 (Interim)
#◎● 33230	U8	with existing dual leads	090	7.00 (Interim)
#◎● 33231	U9	with existing multiple leads <u>(Do not report 33240, 33230, 33231 in conjunction with 33241 for removal and replacement of the pacing cardioverter-defibrillator pulse generator. Use 33262-33264, as appropriate, when pulse generator replacement is indicated)</u> <u>(When epicardial lead placement is performed with insertion of generator, report 33202, 33203 in conjunction with 33240, 33230, 33231)</u>	090	7.25 (Interim)
E ◎ 33241		Subcutaneous r Removal of single or dual chamber pacing cardioverter-defibrillator pulse generator <u>only</u> <u>(For removal and replacement of a pacing cardioverter-defibrillator pulse generator and electrode(s), use 33241 in conjunction with either 33243 or 33244 and 33249)</u>	090	3.29 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
#◎● 33262	U10	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system	090	6.30 (Interim)
#◎● 33263	U11	dual lead system	090	6.30 (Interim)
#◎● 33264	U12	multiple lead system <u>(Do not report 33262-33264 in conjunction with 33241)</u> (For removal of electrode[s] by thoracotomy <u>in conjunction with pulse generator removal or replacement, use 33243 in conjunction with 33241, 33262-33264</u>) (For removal of electrode[s] by transvenous extraction <u>in conjunction with pulse generator removal or replacement, use 33244 in conjunction with 33241, 33262-33264</u>) (For removal and reinsertion of a pacing cardioverter-defibrillator system [pulse generator and electrodes], report 33241 and 33243 or 33244 and 33249) (For repair of implantable cardioverter-defibrillator pulse generator and/or leads, see 33218, 33220)	090	6.53 (Interim)
E ◎33243		Removal of single or dual chamber pacing cardioverter-defibrillator electrode(s); by thoracotomy	090	23.57 (No Change)
E 33244		by transvenous extraction (For subcutaneous removal of the pulse generator, use 33241 in conjunction with 33243 or 33244)	090	13.99 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
E ©33249		<p>Insertion or repositioning replacement of electrode permanent pacing cardioverter-defibrillator system with transvenous lead(s) for single or dual chamber pacing cardioverter defibrillator and insertion of pulse generator</p> <p>(For removal and reinsertion replacement of a pacing cardioverter-defibrillator system ([pulse generator and electrodes]), report 33241 and <u>in conjunction with either 33243 or 33244 and 33249</u>)</p> <p>(For insertion of implantable cardioverter-defibrillator lead(s), without thoracotomy, use 33216 or 33217)</p>	090	15.17 (No Change)
Radiology Diagnostic Radiology (Diagnostic Imaging) Chest				
D 71090		<p>Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation</p> <p><u>(71090 has been deleted. To report pacemaker or pacing cardioverter-defibrillator lead insertion, replacement, or revision procedures with fluoroscopic guidance, see 33206-33249. To report fluoroscopic guidance for diagnostic lead evaluation without lead insertion, replacement, or revision procedures, use 76000)</u></p>	XXX	N/A

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

CPT Code: 33212 Tracking Number U1 Original Specialty Recommended RVU: **5.52**
Presented Recommended RVU: **5.52**
Global Period: 090 RUC Recommended RVU: **5.39**

CPT Descriptor: Insertion of pacemaker pulse generator only with existing; single lead

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68 year old patient presents with complete heart block and existing lead placed during a separate surgical procedure. The patient has no signs of systemic infection and needs implantation of a single chamber pacemaker pulse generator and attachment to existing lead.

Percentage of Survey Respondents who found Vignette to be Typical: 69%

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 75% , Kept overnight (less than 24 hours) 25% , Admitted (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? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 92%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 19%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made in the subclavicular region and carried to the pectoralis fascia or the subpectoral region. A pocket for the pacemaker generator is created either in the plane of pectoralis fascia or underneath the pectoral muscles just above the ribcage. The existing lead is dissected free from fibrous tissue. Hemostasis is achieved. The lead is tested for sensing, capture threshold and impedance. The pocket is irrigated. The pacing lead is connected to the new generator. The generator is inserted into the pocket. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The

patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Richard Wright, MD; Robert Kowal, MD; Bruce Wilkoff, MD					
Specialty(s):	American College of Cardiology, Heart Rhythm Society					
CPT Code:	33212					
Sample Size:	369	Resp N:	36	Response:	9.7 %	
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	2.75	20.00	35.00	200.00
Survey RVW:		4.00	5.39	6.00	7.81	12.00
Pre-Service Evaluation Time:				15.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				20.00		
Intra-Service Time:		20.00	33.75	45.00	60.00	120.00
Immediate Post Service-Time:		27.50				
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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00		
Office time/visit(s):	46.00	99211x 0.00	12x 0.00	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:	33212	Recommended Physician Work RVU: 5.39				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time		
Pre-Service Evaluation Time:		15.00	19.00	-4.00		
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:		45.00				
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):	23.00	99211x 0.00	12x 0.00	13x 1.00	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33222	090	5.10	RUC Time

CPT Descriptor Revision or relocation of skin pocket for pacemaker**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
20103	010	5.34	RUC Time	1,514
<u>CPT Descriptor 1</u> Exploration of penetrating wound (separate procedure); extremity				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52342	000	5.85	RUC Time	291

CPT Descriptor 2 Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
28039	090	5.42	RUC Time

CPT Descriptor Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 41.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33212	<u>Key Reference CPT Code:</u> 33222	<u>Source of Time</u> RUC Time
Median Pre-Service Time	21.00	60.00	
Median Intra-Service Time	45.00	112.00	
Median Immediate Post-service Time	20.00	60.00	
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	23.0	48.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	128.00	280.00	
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	2.79	2.57
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.79	2.50
--	------	------

Urgency of medical decision making	2.71	2.64
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.71	2.64
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Physical effort required	2.50	2.50
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.57	2.50
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Outcome depends on the skill and judgment of physician	2.93	2.93
--	------	------

Estimated risk of malpractice suit with poor outcome	2.64	2.64
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.79	2.71
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Intra-Service intensity/complexity	2.71	2.57
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Post-Service intensity/complexity	2.71	2.57
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Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code and an extrapolation of an estimated 99% decrease in utilization. The panel believes 2/3 of the total utilization will be provided to Medicare patients.

Specialty cardiology 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? 135
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code and an extrapolation of an estimated 90% decrease in utilization.

Specialty cardiology Frequency Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

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 33212

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: 33213 Tracking Number U2 Original Specialty Recommended RVU: **6.30**
Presented Recommended RVU: **6.00**
Global Period: 090 RUC Recommended RVU: **5.61**

CPT Descriptor: Insertion of pacemaker pulse generator only with existing; dual leads

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 82 year-old patient presents with third degree AV block and existing leads placed during a separate surgical procedure. The patient has no signs of systemic infection and needs implantation of a dual chamber pacemaker pulse generator and attachment to existing leads.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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 81% , Kept overnight (less than 24 hours) 19% , Admitted (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? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 93%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 10%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made in the subclavicular region and carried to the pectoralis fascia or the subpectoral region. A pocket for the pacemaker generator is created either in the plane of pectoralis fascia or underneath the pectoral muscles just above the ribcage. The existing leads are dissected free from fibrous tissue. Hemostasis is achieved. The leads are tested for sensing, capture threshold and impedance. The pocket is irrigated. The pacing leads are connected to the new generator. The generator is inserted into the pocket. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The

patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Richard Wright, MD, Robert Kowal, MD, Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Society				
CPT Code:	33213				
Sample Size:	379	Resp N:	32	Response:	8.4 %
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	2.00	17.50	30.00
Survey RVW:		4.90	5.61	6.30	7.94
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		20.00	35.00	50.00	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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:	33213	Recommended Physician Work RVU: 5.61		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		15.00	19.00	-4.00
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:		50.00		
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33222	090	5.10	RUC Time

CPT Descriptor Revision or relocation of skin pocket for pacemaker**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11646	010	6.26	RUC Time	11,281
<u>CPT Descriptor 1</u> Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
29893	090	6.32	RUC Time	1,529

CPT Descriptor 2 Endoscopic plantar fasciotomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
49585	090	6.59	RUC Time

CPT Descriptor Repair umbilical hernia, age 5 years or older; reducible**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 35.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33213	<u>Key Reference CPT Code:</u> 33222	<u>Source of Time</u> RUC Time
Median Pre-Service Time	21.00	60.00	
Median Intra-Service Time	50.00	112.00	
Median Immediate Post-service Time	20.00	60.00	
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	23.0	48.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	133.00	280.00	
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	2.64
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.73	2.45
--	------	------

Urgency of medical decision making	2.64	2.45
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.18	2.91
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Physical effort required	2.64	2.55
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.82	2.73
---	------	------

Outcome depends on the skill and judgment of physician	3.27	3.09
--	------	------

Estimated risk of malpractice suit with poor outcome	2.91	2.82
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.73	2.64
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Intra-Service intensity/complexity	2.82	2.64
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Post-Service intensity/complexity	2.82	2.73
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Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code and an extrapolation of an estimated 99% decrease in utilization. The panel believes 2/3 of the total utilization will be provided to Medicare patients.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 486
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code and an extrapolation of an estimated 99% decrease in utilization.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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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 33213

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:33221 Tracking Number U3 Original Specialty Recommended RVU: **7.00**
Presented Recommended RVU: **6.48**
Global Period: 090 RUC Recommended RVU: **6.00**

CPT Descriptor: Insertion of pacemaker pulse generator only with existing; multiple leads

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 42-year-old patient with congenital heart disease presents with systolic heart failure and left bundle branch block (LBBB). During a prior surgical procedure, pacemaker leads were placed in the right atrium (RA), right ventricle (RV) and left ventricle (LV) in anticipation of need for pacing and tunneled subcutaneously. The patient now meets indications for biventricular pacing.

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 100% , 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 71% , Kept overnight (less than 24 hours) 21% , Admitted (more than 24 hours) 6%

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 71%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 90%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 31%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made in the subclavicular region and carried to the pectoralis fascia or the subpectoral region. A pocket for the pacemaker generator is created either in the plane of pectoralis fascia or underneath the pectoral muscles just above the ribcage. The existing leads are dissected free from fibrous tissue. Hemostasis is achieved. The leads are tested for sensing, capture threshold and impedance. The pocket is irrigated. The pacing leads are connected to the new generator. The generator is inserted into the pocket. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any

required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Richard Wright, MD, Robert Kowal, MD, Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Society				
CPT Code:	33221				
Sample Size:	378	Resp N:	33	Response:	8.7 %
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	0.00	5.00	20.00
Survey RVW:		5.20	6.00	7.00	8.50
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		25.00	45.00	60.00	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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:	33221	Recommended Physician Work RVU: 6.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		15.00	19.00	-4.00
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:		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:	19.00	99238x 0.5	99239x 0.0	99217x 0.00
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33223	090	6.55	RUC Time

CPT Descriptor Revision of skin pocket for cardioverter-defibrillator**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
58560	000	6.99	RUC Time	61

CPT Descriptor 1 Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
30520	090	7.01	RUC Time	20,831

CPT Descriptor 2 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
15823	090	6.81	RUC Time

CPT Descriptor Blepharoplasty, upper eyelid; with excessive skin weighting down lid**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 34.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33221	<u>Key Reference CPT Code:</u> 33223	<u>Source of Time</u> RUC Time
Median Pre-Service Time	21.00	53.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	20.00	60.00	
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	23.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	143.00	235.00	
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	3.64	2.91
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	2.82
--	------	------

Urgency of medical decision making	3.45	2.91
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.64	3.09
--------------------------	------	------

Physical effort required	3.64	2.91
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.82	2.91
---	------	------

Outcome depends on the skill and judgment of physician	4.00	3.27
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.45
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.55	3.27
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Intra-Service intensity/complexity	3.91	2.73
------------------------------------	------	------

Post-Service intensity/complexity	3.27	3.09
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Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

ACC and HRS convened a panel of physicians familiar with the services to review the survey data. Overall, the panel noted that surveyed physicians may have had some difficulty in differentiating between the new bundled codes and the component codes that were being reviewed as part of the same survey. However, the survey was robust and was completed by physicians who have significant experience with each of the services.

The physicians reviewed the data for code 33221, used to report the insertion of a multiple lead pacemaker pulse generator without having first removed another pulse generator. This service will be reported very uncommonly. The physicians reviewed the data. After review, the physicians noted that the median survey value of 7.00 was higher than the current value of 6.37. The current value was calculated based on a 50% reduction placed on the lesser valued code as part of a multiple procedure edit. The panel felt the survey median of 7.00 adequately represents the physician work for the procedure. They noted that when the code to report the current service was valued, only dual lead pacemakers existed. The subsequent development of new technology with three or more leads and resulting increase in value is consistent with the survey and meets the requirement for compelling evidence.

The panel reviewed the preservice time and selected package 1b, a straightforward patient and a straightforward procedure with sedation. The service is generally performed under conscious sedation which is included as part of the code. The package was adjusted to reduce the preservice evaluation time from 19 minutes to 15 minutes to reflect the data from the survey.

The panel noted that the survey showed that the service is commonly performed in a hospital but the patient is sent home the same day. Based on the newly established RUC standard, the panel included a half-day hospital discharge as part of the recommendation as well.

The key reference service for the code was 33223, revision of skin pocket for cardioverter-defibrillator. Those who selected the service believed that the surveyed code was much more complex than this reference service.

The panel noted that the percentage of respondents who reviewed the vignette and found it to be typical was low at 56%. After reviewing the responses, the physicians believed that the physicians who indicated that the vignette was not typical were confused by the new coding mechanism and thought that the typical patient would be one in which a pulse generator was removed and replaced. The panel believed that this lack of understanding could only cause a reduction in work values from a surveyee to report a more commonly performed service.

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) 33213

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.

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

CPT Code: 33227 Tracking Number U4 Original Specialty Recommended RVU: **7.22**
Presented Recommended RVU: **6.05**
Global Period: 090 RUC Recommended RVU: **4.85**

CPT Descriptor: Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 85-year-old patient presents with a history of complete heart block whose pacemaker generator is at elective replacement indicator. The patient has no evidence of systemic infection or decompensated congestive heart failure (CHF).

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 100% , 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 92% , Kept overnight (less than 24 hours) 5% , Admitted (more than 24 hours) 2%

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 100%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 90%

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? 31%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made of the existing generator and carried down to the level of the capsule surrounding the generator. The existing generator is dissected free and the lead is freed from fibrous scar tissue. This must be performed in a manner preventing damage to the lead. Often extensive removal of scar tissue/capsule is required. During the procedure adequate hemostasis and sterility are maintained. The existing lead is tested to assess the adequacy, including capture threshold, sensing and impedance. The pocket may need to be modified to accommodate the shape and size of the new generator. The pocket is copiously irrigated. The new generator is inserted in the pocket and attached to the existing lead. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Richard Wright, MD; Robert Kowal, MD; Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Society				
CPT Code:	33227				
Sample Size:	365	Resp N:	39	Response: 10.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	20.50	30.00	50.00
Survey RVW:		5.00	6.00	7.25	9.90
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		10.00	30.00	45.00	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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:	33227	Recommended Physician Work RVU: 4.85		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		15.00	19.00	-4.00
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:		45.00		
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33222	090	5.10	RUC Time

CPT Descriptor REVISION OR RELOCATION OF SKIN POCKET FOR PACEMAKER**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31600	000	7.17	RUC Time	40,374
<u>CPT Descriptor 1</u> Tracheostomy, planned (separate procedure);				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
46262	090	7.91	RUC Time	226

CPT Descriptor 2 Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
42440	090	7.13	RUC Time

CPT Descriptor Excision of submandibular (submaxillary) gland**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 9 % of respondents: 23.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33227	<u>Key Reference CPT Code:</u> 33222	<u>Source of Time</u> RUC Time
Median Pre-Service Time	21.00	60.00	
Median Intra-Service Time	45.00	112.00	
Median Immediate Post-service Time	20.00	60.00	
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	23.0	48.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	128.00	280.00	
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	2.89	2.78
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.78
--	------	------

Urgency of medical decision making	2.89	2.78
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.11	3.00
--------------------------	------	------

Physical effort required	2.78	2.78
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.56
---	------	------

Outcome depends on the skill and judgment of physician	3.00	3.00
--	------	------

Estimated risk of malpractice suit with poor outcome	2.89	2.89
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	2.78
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Intra-Service intensity/complexity	3.11	3.00
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Post-Service intensity/complexity	2.78	2.78
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Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code and an extrapolation of an estimated 71% decrease in utilization. The panel believes 2/3 of the total utilization will be provided to Medicare patients.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 14,818 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code and an extrapolation of an estimated 71% decrease in utilization.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 33223

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

CPT Code:33228 Tracking Number U5 Original Specialty Recommended RVU: **7.68**
Presented Recommended RVU: **6.53**
Global Period: 090 RUC Recommended RVU: **5.05**

CPT Descriptor: Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 82-year-old patient presents with a history of sick sinus syndrome and intermittent paroxysmal atrial fibrillation. The pacemaker is at elective replacement indicator. The patient has no evidence of systemic infection. The patient is complaining of dyspnea felt to be related to a rate or mode change due to the device reaching elective replacement indicator.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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 89% , Kept overnight (less than 24 hours) 8% , Admitted (more than 24 hours) 3%

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 100%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 92%

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? 36%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made of the existing generator and carried down to the level of the capsule surrounding the generator. The existing generator is dissected free and the leads are freed from fibrous scar tissue. Often extensive removal of scar tissue/capsule is required. This must be performed in a manner preventing damage to the leads. During the procedure adequate hemostasis and sterility are maintained. The existing leads are tested to assess the adequacy, including capture threshold, sensing and impedance. The pocket may need to be modified to accommodate the shape and size of the new generator. The pocket is copiously irrigated. The new generator is inserted in the pocket and attached to the existing leads. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Richard Wright, MD; Robert Kowal, MD; Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Society				
CPT Code:	33228				
Sample Size:	384	Resp N:	36	Response:	9.3 %
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	20.00	30.00	50.00
Survey RVW:		5.20	6.19	7.68	11.00
Pre-Service Evaluation Time:				20.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		30.00	35.00	45.00	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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:	33228	Recommended Physician Work RVU: 5.05		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		45.00		
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33223	090	6.55	RUC Time

CPT Descriptor Revision of skin pocket for cardioverter-defibrillator**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31600	000	7.17	RUC Time	40,374

CPT Descriptor 1 Tracheostomy, planned (separate procedure);

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
46262	090	7.91	RUC Time	226

CPT Descriptor 2 Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
67901	090	7.59	RUC Time

CPT Descriptor Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 7 % of respondents: 19.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33228	<u>Key Reference CPT Code:</u> 33223	<u>Source of Time</u> RUC Time
Median Pre-Service Time	25.00	53.00	
Median Intra-Service Time	45.00	90.00	
Median Immediate Post-service Time	20.00	60.00	
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	23.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	132.00	235.00	
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	3.00	2.57
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.86	2.57
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Urgency of medical decision making	3.00	2.86
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.43	2.86
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Physical effort required	3.29	2.71
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.71	2.43
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Outcome depends on the skill and judgment of physician	3.14	2.71
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Estimated risk of malpractice suit with poor outcome	3.14	3.00
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.86	2.86
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Intra-Service intensity/complexity	3.14	2.71
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Post-Service intensity/complexity	2.71	2.71
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Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code combination and expert opinion of physicians. The panel believes 2/3 of the total utilization will be provided to Medicare patients.

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? 35,257 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. These estimates are based on reviews of the number of claims reported for codes 33213 and 33233 in 2009 and expert opinion on the percentage that would be reported as dual or multiple lead pacemaker.

Specialty	Frequency	Percentage	%
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

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. 33223

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

CPT Code:33229 Tracking Number U6 Original Specialty Recommended RVU: **8.00**
Presented Recommended RVU: **7.01**
Global Period: 090 RUC Recommended RVU: **5.40**

CPT Descriptor: Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 84-year-old patient presents with moderate to severe congestive heart failure (CHF) and left bundle branch block (LBBB) and does not wish to have implantable cardioverter-defibrillator (ICD) therapy. The biventricular pacemaker is at elective replacement indicator. There is no evidence of systemic infection.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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 84% , Kept overnight (less than 24 hours) 13% , Admitted (more than 24 hours) 30%

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 50%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 84%

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? 32%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made of the existing generator and carried down to the level of the capsule surrounding the generator. The existing generator is dissected free and the leads are freed from fibrous scar tissue. Often extensive removal of scar tissue/capsule is required. This must be performed in a manner preventing damage to the leads. During the procedure adequate hemostasis and sterility are maintained. The existing leads are tested to assess the adequacy, including capture threshold, sensing and impedance. The pocket may need to be modified to accommodate the shape and size of the new generator. The pocket is copiously irrigated. The new generator is inserted in the pocket and attached to the existing leads. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Richard Wright, MD; Robert Kowal, MD; Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Society				
CPT Code:	33229				
Sample Size:	361	Resp N:	31	Response: 8.5 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	2.50	10.00	25.00
Survey RVW:		5.55	6.90	8.00	11.00
Pre-Service Evaluation Time:				20.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		30.00	40.00	50.00	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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:	33229	Recommended Physician Work RVU: 5.40		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		50.00		
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33223	090	6.55	RUC Time

CPT Descriptor Revision of skin pocket for cardioverter-defibrillator**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
67904	090	7.97	RUC Time	50,099
<u>CPT Descriptor 1</u> Repair of blepharoptosis; (tarso) levator resection or advancement, external approach				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
43269	000	8.20	RUC Time	19,896

CPT Descriptor 2 Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36831	090	8.04	RUC Time

CPT Descriptor Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Key Reference Code: 10 % of respondents: 32.2 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33229	<u>Key Reference CPT Code:</u> 33223	<u>Source of Time</u> RUC Time
Median Pre-Service Time	25.00	53.00	
Median Intra-Service Time	50.00	90.00	
Median Immediate Post-service Time	20.00	60.00	
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	23.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	137.00	235.00	

Other time if appropriate		
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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	3.50	2.90
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	2.80
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Urgency of medical decision making	3.00	2.90
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.40	3.10
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Physical effort required	3.10	2.90
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.20	2.70
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Outcome depends on the skill and judgment of physician	3.10	2.90
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Estimated risk of malpractice suit with poor outcome	3.30	3.20
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.60	3.10
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Intra-Service intensity/complexity	3.30	2.90
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Post-Service intensity/complexity	3.10	2.90
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Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

Estimate the number of times this service might be provided nationally in a one-year period? 1950

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior codes 33213 and 33233 and physician expert opinion on the distribution of dual and multiple lead pacemakers. The panel believes 2/3 of the total utilization will be provided to Medicare patients.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,023

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior codes 33213 and 33233 and physician expert opinion on the distribution of dual and multiple lead pacemakers.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 33223

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

CPT Code:33240 Tracking Number U7 Original Specialty Recommended RVU: **7.00**
 Presented Recommended RVU: **7.00**
 Global Period: 090 RUC Recommended RVU: **7.00**

CPT Descriptor: Insertion of pacing cardioverter-defibrillator pulse generator only with existing; single lead

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64 year old patient presents with history of coronary artery disease, old myocardial infarction approximately 3-4 years ago with depressed left ventricular function with ejection fraction of 34% and existing lead placed during a separate surgical procedure. The patient has no signs of systemic infection and needs implantation of a single chamber ICD generator and attachment to existing lead to complete a functional system

Percentage of Survey Respondents who found Vignette to be Typical: 53%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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 57% , Kept overnight (less than 24 hours) 37% , Admitted (more than 24 hours) 7%

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 45%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 83%

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? 17%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made in the subclavicular region and carried to the pectoralis fascia or the subpectoral region. A pocket for the pacemaker generator is created either in the plane of pectoralis fascia or underneath the pectoral muscles just above the ribcage. The existing lead is dissected free from fibrous tissue. Hemostasis is achieved. The lead is tested for sensing, capture threshold and impedance. The pocket is irrigated. The pacing lead is connected to the new generator. The generator is inserted into the pocket. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any

required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Richard Wright, MD; Robert Kowal, MD; Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Societyf				
CPT Code:	33240				
Sample Size:	372	Resp N:	30	Response:	8.0 %
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	2.00	12.50	48.75
Survey RVW:		4.90	7.00	8.25	11.00
Pre-Service Evaluation Time:				17.50	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		30.00	40.00	60.00	69.75
Immediate Post Service-Time:		22.50			
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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:	33240	Recommended Physician Work RVU: 7.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		17.50	33.00	-15.50
Pre-Service Positioning Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:		25.00		
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33223	090	6.55	RUC Time

CPT Descriptor Revision of skin pocket for cardioverter-defibrillator**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
58560	000	6.99	RUC Time	61

CPT Descriptor 1 Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
30520	090	7.01	RUC Time	20,831

CPT Descriptor 2 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
42440	090	7.13	RUC Time

CPT Descriptor Excision of submandibular (submaxillary) gland**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 36.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33240	<u>Key Reference CPT Code:</u> 33223	<u>Source of Time</u> RUC Time
Median Pre-Service Time	35.50	53.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	25.00	60.00	
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	23.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	162.50	235.00	
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	2.82
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.09	2.73
Urgency of medical decision making	2.73	2.73

Technical Skill/Physical Effort (Mean)

Technical skill required	3.36	3.45
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Physical effort required	3.27	3.27
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.55	3.45
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Outcome depends on the skill and judgment of physician	3.73	3.73
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Estimated risk of malpractice suit with poor outcome	3.64	3.64
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INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.09	3.09
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Intra-Service intensity/complexity	3.36	3.09
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Post-Service intensity/complexity	2.91	2.82
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Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

Estimate the number of times this service might be provided nationally in a one-year period? 426

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 284

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code and expert opinion on the distribution of codes based on the number of leads.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 33223

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

CPT Code: 33230 Tracking Number U8 Original Specialty Recommended RVU: **7.64**
 Presented Recommended RVU: **7.48**
 Global Period: 090 RUC Recommended RVU: **7.00**

CPT Descriptor: Insertion of pacing cardioverter-defibrillator pulse generator only with existing; dual leads

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year old patient presents with systolic heart failure and existing leads placed during a separate surgical procedure. The patient has no signs of systemic infection and needs implantation of a dual chamber ICD generator and attachment to existing leads to complete a functional system.

Percentage of Survey Respondents who found Vignette to be Typical: 60%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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 64% , Kept overnight (less than 24 hours) 32% , Admitted (more than 24 hours) 4%

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 50%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 80%

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? 28%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made in the subclavicular region and carried to the pectoralis fascia or the subpectoral region. A pocket for the pacemaker generator is created either in the plane of pectoralis fascia or underneath the pectoral muscles just above the ribcage. The existing leads are dissected free from fibrous tissue. Hemostasis is achieved. The leads are tested for sensing, capture threshold and impedance. The pocket is irrigated. The pacing leads are connected to the new generator. The generator is inserted into the pocket. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The

patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Richard Wright, MD; Robert Kowal, MD; Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Society				
CPT Code:	33230				
Sample Size:	451	Resp N:	25	Response: 5.5 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	3.00	15.00	40.00
Survey RVW:		5.00	7.00	9.50	12.50
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		30.00	40.00	60.00	75.00
Immediate Post Service-Time:	30.00				
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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	46.00	99211x 0.00	12x 0.00	13x 2.00	14x 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:	33230	Recommended Physician Work RVU: 7.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		15.00	33.00	-18.00
Pre-Service Positioning Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	30.00			
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33223	090	6.55	RUC Time

CPT Descriptor Revision of skin pocket for cardioverter-defibrillator**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31600	000	7.17	RUC Time	40,374

CPT Descriptor 1 Tracheostomy, planned (separate procedure);

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
46262	090	7.91	RUC Time	226

CPT Descriptor 2 Hemorrhoidectomy, internal and external, 2 or more columns/groups; with fistulectomy, including fissurectomy, when performed

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
67901	090	7.59	RUC Time

CPT Descriptor Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 8 % of respondents: 32.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33230	<u>Key Reference CPT Code:</u> 33223	<u>Source of Time</u> RUC Time
Median Pre-Service Time	33.00	53.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	30.00	60.00	
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	23.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	165.00	235.00	
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	3.25	3.00
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.13
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Urgency of medical decision making	3.25	3.13
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.75
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Physical effort required	3.63	3.63
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.25
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Outcome depends on the skill and judgment of physician	3.50	3.63
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Estimated risk of malpractice suit with poor outcome	4.00	3.63
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	3.13
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Intra-Service intensity/complexity	3.50	3.13
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Post-Service intensity/complexity	3.00	2.88
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Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

ACC and HRS convened a panel of physicians familiar with the services to review the survey data. Overall, the panel noted that surveyed physicians may have had some difficulty in differentiating between the new bundled codes and the component codes that were being reviewed as part of the same survey. The survey had a lower response than desired due to the large number of surveys that were being collected at the time.

The physicians reviewed the data for code 33230, used to report the insertion of a dual lead pacing cardioverter-defibrillator pulse generator without having first removed another pulse generator. This service will be reported very uncommonly. After reviewing the data, the physicians noted that the median survey value of 9.50 was higher than the current value of 7.64. The current value was calculated based on a 50% reduction placed on the lesser valued code as part of a multiple procedure edit. The panel did not feel that an argument could be made for compelling evidence to increase the work value for the service.

The panel reviewed the preservice time and selected package 3, a straightforward patient and a difficult procedure with sedation. The service is generally performed under IV deep sedation and local anesthesia or under general anesthesia. The package was adjusted to reduce the preservice evaluation time from 33 minutes to 15 minutes to reflect the data from the survey.

The panel noted that the survey showed that the service is commonly performed in a hospital but the patient is sent home the same day. Based on the newly established RUC standard, the panel included a half-day hospital discharge as part of the recommendation as well.

The key reference service for the code was 33223, revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator. Those who selected the service believed that the surveyed code was somewhat more complex than the reference service.

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) 33240 - this service was split into three codes to report the number of leads to be consistent with other device codes

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 cardiology How often? Commonly

Specialty general surgery How often? Rarely

Specialty thoracic surgery How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 503

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data. Based on 2009 Medicare Part B Claims Data for the prior code and expert opinion on the distribution of services based on the number of leads.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 335

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 33223

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

CPT Code: 33231 Tracking Number U9 Original Specialty Recommended RVU: **8.28**
Presented Recommended RVU: **7.96**
Global Period: 090 RUC Recommended RVU: **7.25**

CPT Descriptor: Insertion of pacing cardioverter-defibrillator pulse generator only with existing; multiple leads

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62 year patient presents with systolic heart failure and LBBB block. During a separate surgical procedure, right atrial (RA), right ventricular (RV) and left ventricular (LV) leads were placed. The patient requires implantation of a biventricular ICD generator with attachment with existing leads to complete the ICD system.

Percentage of Survey Respondents who found Vignette to be Typical: 48%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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 70% , Kept overnight (less than 24 hours) 22% , Admitted (more than 24 hours) 7%

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 50%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 78%

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? 19%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made in the subclavicular region and carried to the pectoralis fascia or the subpectoral region. A pocket for the pacemaker generator is created either in the plane of pectoralis fascia or underneath the pectoral muscles just above the ribcage. The existing leads are dissected free from fibrous tissue. Hemostasis is achieved. The leads are tested for sensing, capture threshold and impedance. The pocket is irrigated. The pacing leads are connected to the new generator. The generator is inserted into the pocket. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The

patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Richard Wright, MD; Robert Kowal, MD; Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Society				
CPT Code:	33231				
Sample Size:	448	Resp N:	27	Response:	6.0 %
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	0.00	15.00	37.50
Survey RVW:		5.10	7.25	9.50	14.30
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		30.00	45.00	60.00	90.00
Immediate Post Service-Time:	30.00				
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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:	33231	Recommended Physician Work RVU: 7.25		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		15.00	33.00	-18.00
Pre-Service Positioning Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	30.00			
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33223	090	6.55	RUC Time

CPT Descriptor Revision of skin pocket for cardioverter-defibrillator**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
43269	000	8.20	RUC Time	19,896
<u>CPT Descriptor 1</u> Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
14040	090	8.60	RUC Time	82,511

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
28175	090	8.29	RUC Time

CPT Descriptor Radical resection of tumor; phalanx of toe**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 8 % of respondents: 32.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33231	<u>Key Reference CPT Code:</u> 33223	<u>Source of Time</u> RUC Time
Median Pre-Service Time	33.00	53.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	30.00	60.00	
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	23.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	165.00	235.00	

Other time if appropriate		
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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	3.44	3.00
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.44	3.00
--	------	------

Urgency of medical decision making	3.22	3.11
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.44	3.56
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Physical effort required	3.44	3.22
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.44	3.00
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Outcome depends on the skill and judgment of physician	3.44	3.67
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Estimated risk of malpractice suit with poor outcome	3.78	3.56
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.33	3.11
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Intra-Service intensity/complexity	3.56	3.00
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Post-Service intensity/complexity	3.11	2.89
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Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

ACC and HRS convened a panel of physicians familiar with the services to review the survey data. Overall, the panel noted that surveyed physicians may have had some difficulty in differentiating between the new bundled codes and the component codes that were being reviewed as part of the same survey. However, the survey was robust and was completed by physicians who have significant experience with each of the services.

The physicians reviewed the data for code 33231, used to report the insertion of a multiple lead pacing cardioverter-defibrillator pulse generator without having first removed another pulse generator. This service will be reported very uncommonly. After reviewing the data, the physicians noted that the median survey value of 9.50 was higher than the current value of 7.64. The current value was calculated based on a 50% reduction placed on the lesser valued code as part of a multiple procedure edit.

The panel reviewed the preservice time and selected package 3, a straightforward patient and a difficult procedure with sedation. The service is generally performed under IV deep sedation and local anesthesia or under general anesthesia, which is included as part of the code. The package was adjusted to reduce the preservice evaluation time from 33 minutes to 15 minutes to reflect the data from the survey.

The panel noted that the survey showed that the service is commonly performed in a hospital but the patient is sent home the same day. Based on the newly established RUC standard, the panel included a half-day hospital discharge as part of the recommendation as well.

The key reference service for the code was 33223, revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator. Those who selected the service believed that the surveyed code was somewhat more complex to similar in complexity to the reference service.

The panel noted that only 48% of the surveyed population considered the vignette to be typical. After reviewing the responses to this question, the panel felt that this represented a lack of understanding of the new code and its relation to a bundled code. Those who indicated that it was not typical indicated that a typical case is much more like the bundled code which is to be expected.

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) 33240 - this code was split into three codes to reflect the number of leads to be consistent with other device codes

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 cardiology

How often? Commonly

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

CPT Code:33262 Tracking Number U10

Original Specialty Recommended RVU: **8.68**Presented Recommended RVU: **7.82**

Global Period: 090

RUC Recommended RVU: **6.30**

CPT Descriptor: Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old patient presents with systolic congestive heart failure (CHF) from prior myocardial infarction whose implantable cardioverter-defibrillator (ICD) is at elective replacement indicator. The patient has no signs of systemic infection or unstable coronary syndrome.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 97% , In the ASC 0%, In the office 2%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 84% , Kept overnight (less than 24 hours) 10% , Admitted (more than 24 hours) 5%

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 25%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 87%

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? 33%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made of the existing generator and carried down to the level of the capsule surrounding the generator. The existing generator is dissected free and the lead is freed from fibrous scar tissue. This must be performed in a manner preventing damage to the lead. Often extensive removal of scar tissue/capsule is required. During the procedure adequate hemostasis and sterility are maintained. The existing lead is tested to assess the adequacy, including capture threshold, sensing and impedance. The pocket may need to be modified to accommodate the shape and size of the new generator. The pocket is copiously irrigated. The new generator is inserted in the pocket and attached to the existing lead. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Richard Wright, MD; Robert Kowal, MD; Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Society				
CPT Code:	33262				
Sample Size:	375	Resp N:	39	Response: 10.4 %	
Sample Type:	Convenience		Additional Sample Information: convenience and random		
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	25.00	30.00	65.50
Survey RVW:		5.10	6.28	7.25	9.75
Pre-Service Evaluation Time:				20.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		30.00	40.00	45.00	60.00
Immediate Post Service-Time:		25.00			
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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	80.00	99211x 0.00	12x 0.00	13x 0.00	14x 2.00
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:	33262	Recommended Physician Work RVU: 6.30		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		20.00	33.00	-13.00
Pre-Service Positioning Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		45.00		
Immediate Post Service-Time:		25.00		
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33223	090	6.55	RUC Time

CPT Descriptor Revision of skin pocket for cardioverter-defibrillator**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
14040	090	8.60	RUC Time	82,511

CPT Descriptor 1 Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
14060	090	9.23	RUC Time	98,372

CPT Descriptor 2 Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
52400	090	8.68	RUC Time

CPT Descriptor Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 36.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33262	<u>Key Reference CPT Code:</u> 33223	<u>Source of Time</u> RUC Time
Median Pre-Service Time	38.00	53.00	
Median Intra-Service Time	45.00	90.00	
Median Immediate Post-service Time	25.00	60.00	
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	23.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	150.00	235.00	

Other time if appropriate		
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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	3.14	2.93
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.36	3.07
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Urgency of medical decision making	3.14	2.93
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.36	3.29
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Physical effort required	2.93	2.89
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.29	3.14
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Outcome depends on the skill and judgment of physician	3.29	3.21
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Estimated risk of malpractice suit with poor outcome	3.21	3.14
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.14	3.07
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Intra-Service intensity/complexity	3.21	3.07
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Post-Service intensity/complexity	3.00	3.00
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Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

Specialty thoracic surgery

How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 10063

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6,098If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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 numberIf 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. 33223

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

CPT Code:33263 Tracking Number U11

Original Specialty Recommended RVU: **9.29**Presented Recommended RVU: **8.30**

Global Period: 090

RUC Recommended RVU: **6.30**

CPT Descriptor: Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old patient with systolic congestive heart failure (CHF) from prior myocardial infarction (MI), who also has bradycardia, presents with an implantable cardioverter-defibrillator (ICD) at elective replacement indicator. The patient has no signs of systemic infection or unstable coronary syndrome.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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 82% , Kept overnight (less than 24 hours) 12% , Admitted (more than 24 hours) 6%

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 25%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 91%

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? 37%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made of the existing generator and carried down to the level of the capsule surrounding the generator. The existing generator is dissected free and the leads are freed from fibrous scar tissue. Often extensive removal of scar tissue/capsule is required. This must be performed in a manner preventing damage to the leads. During the procedure adequate hemostasis and sterility are maintained. The existing leads are tested to assess the adequacy, including capture threshold, sensing and impedance. The pocket may need to be modified to accommodate the shape and size of the new generator. The pocket is copiously irrigated. The new generator is inserted in the pocket and attached to the existing leads. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Richard Wright, MD; Robert Kowal, MD; Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Society				
CPT Code:	33263				
Sample Size:	454	Resp N:	33	Response:	7.2 %
Sample Type:	Convenience	Additional Sample Information: convenience and random			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	25.00	30.00	50.00
Survey RVW:		6.00	7.10	9.50	12.75
Pre-Service Evaluation Time:				20.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		30.00	40.00	60.00	65.00
Immediate Post Service-Time:	30.00				
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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	80.00	99211x 0.00	12x 0.00	13x 0.00	14x 2.00
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:	33263	Recommended Physician Work RVU: 6.30		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		20.00	33.00	-13.00
Pre-Service Positioning Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	30.00			
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33223	090	6.55	RUC Time

CPT Descriptor Revision of skin pocket for cardioverter-defibrillator**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
14060	090	9.23	RUC Time	98,372
<u>CPT Descriptor 1</u> Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
29891	090	9.67	RUC Time	486

CPT Descriptor 2 Arthroscopy, ankle, surgical, excision of osteochondral defect of talus and/or tibia, including drilling of the defect

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 9 % of respondents: 27.2 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33263	<u>Key Reference CPT Code:</u> 33223	<u>Source of Time</u> RUC Time
Median Pre-Service Time	38.00	53.00	
Median Intra-Service Time	60.00	90.00	
Median Immediate Post-service Time	30.00	60.00	
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	23.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	170.00	235.00	
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	3.44	2.89
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.00
--	------	------

Urgency of medical decision making	3.22	3.00
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.78	3.22
--------------------------	------	------

Physical effort required	3.56	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.67	3.11
---	------	------

Outcome depends on the skill and judgment of physician	3.78	3.44
--	------	------

Estimated risk of malpractice suit with poor outcome	3.33	3.11
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.56	3.22
----------------------------------	------	------

Intra-Service intensity/complexity	3.44	3.22
------------------------------------	------	------

Post-Service intensity/complexity	3.33	3.11
-----------------------------------	------	------

Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

Specialty thoracic surgery

How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 25158

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code and expert opinion on the percentage of codes that will be reported with single, dual, or multiple leads.

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?

15,280 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2009 Medicare Part B Claims Data for the prior code.

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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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

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. 33223

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

CPT Code:33264 Tracking Number U12

Original Specialty Recommended RVU: **9.90**Presented Recommended RVU: **8.78**

Global Period: 090

RUC Recommended RVU: **6.53**

CPT Descriptor: Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year-old patient with systolic congestive heart failure (CHF), Class III symptoms and left bundle branch block (LBBB) who presents with an implantable cardioverter-defibrillator (ICD) at elective replacement indicator. The patient has no signs of systemic infection.

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 100% , 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 89% , Kept overnight (less than 24 hours) 5% , Admitted (more than 24 hours) 5%

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 50%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 89%

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? 35%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Patient is evaluated for stability with respect to overall cardiovascular status. A history and multi-system physical exam are obtained. The procedure and its risks are discussed in detail with the patient and patient's family, as well as why pacing is needed, the risks, benefits, indications and alternatives. Mark the incision site and obtain informed consent and answer patient and family questions. Scheduling and follow-up issues are discussed. Medications are often adjusted including insulin, diuretics and anti-coagulants. Monitor the patient positioning and draping and assist with positioning as needed. Scrub and gown. Observe and/or assist in insertion of monitoring lines and induction of anesthesia.

Description of Intra-Service Work: The appropriate pectoral region is prepared and draped in a sterile manner. An incision is made of the existing generator and carried down to the level of the capsule surrounding the generator. The existing generator is dissected free and the leads are freed from fibrous scar tissue. Often extensive removal of scar tissue/capsule is required. This must be performed in a manner preventing damage to the leads. During the procedure adequate hemostasis and sterility are maintained. The existing leads are tested to assess the adequacy, including capture threshold, sensing and impedance. The pocket may need to be modified to accommodate the shape and size of the new generator. The pocket is copiously irrigated. The new generator is inserted in the pocket and attached to the existing leads. The pocket is closed with either suture alone or a combination of suture and staples or suture and tissue adhesive. Programming of the device is performed.

Description of Post-Service Work: Report dictated and temporary immediate post-op sheet is completed. Family is found and updated on patient's status. The wound is assessed with respect to appropriate healing. The dressing is removed. Any required antibiotics or analgesic medications are prescribed. Orders are written and staff are given instructions. The patient is then established on a schedule for periodic appropriate Pacemaker Clinic visits, as well as transtelephonic monitoring.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Richard Wright, MD; Robert Kowal, MD; Bruce Wilkoff, MD				
Specialty(s):	American College of Cardiology, Heart Rhythm Society				
CPT Code:	33264				
Sample Size:	453	Resp N:	37	Response:	8.1 %
Sample Type:	Convenience	Additional Sample Information: convenience and random			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	20.00	25.00	45.00
Survey RVW:		6.00	7.30	9.90	12.85
Pre-Service Evaluation Time:				20.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		30.00	50.00	65.00	75.00
Immediate Post Service-Time:	25.00				
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:	38.00	99238x 0.00	99239x 0.00	99217x 1.00	
Office time/visit(s):	80.00	99211x 0.00	12x 0.00	13x 0.00	14x 2.00
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:	33264	Recommended Physician Work RVU: 6.53		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		20.00	33.00	-13.00
Pre-Service Positioning Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		65.00		
Immediate Post Service-Time:	25.00			
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
33223	090	6.55	RUC Time

CPT Descriptor Revision of skin pocket for cardioverter-defibrillator**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
33973	000	9.75	RUC Time	128

CPT Descriptor 1 Insertion of intra-aortic balloon assist device through the ascending aorta

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
58561	000	9.99	RUC Time	1,136

CPT Descriptor 2 Hysteroscopy, surgical; with removal of leiomyomata

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 10 % of respondents: 27.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 33264	<u>Key Reference CPT Code:</u> 33223	<u>Source of Time</u> RUC Time
Median Pre-Service Time	38.00	53.00	
Median Intra-Service Time	65.00	90.00	
Median Immediate Post-service Time	25.00	60.00	
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	23.0	32.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	170.00	235.00	
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	3.60	2.80
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.90	3.00
--	------	------

Urgency of medical decision making	3.30	2.90
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.80	3.30
--------------------------	------	------

Physical effort required	3.50	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.00
---	------	------

Outcome depends on the skill and judgment of physician	4.00	3.40
--	------	------

Estimated risk of malpractice suit with poor outcome	3.40	3.30
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.60	3.20
----------------------------------	------	------

Intra-Service intensity/complexity	3.80	3.10
------------------------------------	------	------

Post-Service intensity/complexity	3.30	3.00
-----------------------------------	------	------

Additional Rationale and Comments

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

The codes related to pacemaker and internal cardioverter-defibrillator (ICD) removal and replacement were identified by the CPT/RUC Joint Workgroup as being commonly reported together in 2009. The American College of Cardiology and the Heart Rhythm Society were instructed to create bundled services that reflected the commonly provided removal and replacement of a pacemaker or ICD pulse generator. As part of this coding proposal, new codes were added to reflect the availability of pacemakers and ICDs with greater than two leads. A total of 12 codes were created or significantly revised, mandating a RUC survey.

ACC and HRS convened a panel of physicians familiar with the services to review the survey data. Overall, the panel noted that surveyed physicians may have had some difficulty in differentiating between the new bundled codes and the component codes that were being reviewed as part of the same survey. However, the survey was robust and was completed by physicians who have significant experience with each of the services.

The physicians reviewed the data for code 33264, used to report the removal and insertion of a multiple lead pacing cardioverter-defibrillator pulse generator. The physicians reviewed the data. After review, the physicians noted that the median survey value of 9.90 was higher than the current value of 9.29. The current value was calculated based on a 50% reduction placed on the lesser valued code as part of a multiple procedure edit. The panel felt the survey median of 9.90 adequately represents the physician work for the procedure. They noted that when the code to report the current service was valued, only dual lead cardioverter-defibrillators existed. The subsequent development of new technology with three or more leads and resulting increase in value is consistent with the survey and meets the requirement for compelling evidence.

The panel reviewed the preservice time and selected package 3, a straightforward patient and a difficult procedure with sedation. The service is generally performed under IV deep sedation and local anesthesia or under general anesthesia, which is included as part of the code. The package was adjusted to reduce the preservice evaluation time from 33 minutes to 20 minutes to reflect the data from the survey.

The panel noted that the survey showed that the service is commonly performed in a hospital but the patient is sent home the same day. Based on the newly established RUC standard, the panel included a half-day hospital discharge as part of the recommendation as well.

The key reference service for the code was 33223, revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator. Those who selected the service believed that the surveyed code was similar in complexity to the reference service.

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) Previously reported as a combination of codes 33241 and 33240 but was identified as a service commonly performed together by the Relativity Assessment Workgroup.

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 cardiology/electrophysiology

How often? Commonly

Specialty

How often?

CPT Code: 33212-3, 33221, 33227-9, 33240, 33230-1, 33262-4
AMA/Specialty Society RVS Update Committee Recommendation
AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor:

33212	Insertion of pacemaker pulse generator only with existing; single lead
33213	Insertion of pacemaker pulse generator only with existing; dual leads
33221	Insertion of pacemaker pulse generator only with existing; multiple leads
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system
33240	Insertion of pacing cardioverter-defibrillator pulse generator only with existing; single lead
33230	Insertion of pacing cardioverter-defibrillator pulse generator only with existing; dual leads
33231	Insertion of pacing cardioverter-defibrillator pulse generator only with existing; multiple leads
33262	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system
33263	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system
33264	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system

Global Period: 090

Meeting Date: April 2011

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

A specialty panel representing cardiology and electrophysiology discussed the practice expense requirements for the various codes and determined that the standard 90-day global inputs for a straightforward patient and procedure under anesthesia would apply.

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

CPT Code: 33212-3, 33221, 33227-9, 33240, 33230-1, 33262-4
AMA/Specialty Society RVS Update Committee Recommendation

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The standard times have been applied for pre-service clinical labor time.

Intra-Service Clinical Labor Activities:

The standard 6 minutes has been applied for these inpatient procedures for one half discharge day management related services.

Post-Service Clinical Labor Activities:

Standard times to ready patient/records and assist the physician at each post-op office visit have been applied.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	AMA/Specialty Society RVS Update Committee Recommendation			33212		33213		33221		33227		33228		33229	
	Meeting Date: April 2011 Specialty: ACC			Insertion of pacemaker pulse generator only with existing; single lead		Insertion of pacemaker pulse generator only with existing; dual leads		Insertion of pacemaker pulse generator only with existing multiple leads		Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system		Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system		Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	
2		CMS	Staff												
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD				090		090		090		090		090		090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA		102.0		102.0		102.0		102.0		102.0		102.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60.0		60.0		60.0		60.0		60.0		60.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA		6.0		6.0		6.0		6.0		6.0		6.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		36.0		36.0		36.0		36.0		36.0		36.0
9	PRE-SERVICE														
10	Start: Following visit when decision for surgery or procedure made														
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5		5		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20		20		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8		8		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20		20		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7		7		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	L037D	RN/LPN/MTA		6		6		6		6		6		6
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	<i>List Number and Level of Office Visits</i>														
45	99211 16 minutes		16												
46	99212 27 minutes	L037D	27												
47	99213 36 minutes	L037D	36	1		1		1		1		1		1	
48	99214 53 minutes		53												
49	99215 63 minutes		63												
50	99238 12 minutes		12												
51	Total Office Visit Time				36		36		36		36		36		36
52	Other Activity (please specify)														
53	End: with last office visit before end of global period														
54	MEDICAL SUPPLIES														
55	pack, minimum multi-specialty visit	SA048	pack		2		2		2		2		2		2
56	pack, post-op incision care (suture)	SA054	kit		1		1		1		1		1		1
57	Equipment														
58	table, power	EF031	100%		36		36		36		36		36		36
59	light, exam	EQ168	100%		36		36		36		36		36		36

	A	B	C	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1	AMA/Specialty Society RVS Update Committee Recommendation			33240		33230		33231		33262		33263		33264	
	Meeting Date: April 2011 Specialty: ACC			Insertion of pacing cardioverter-defibrillator pulse generator only with existing; single lead		Insertion of pacing cardioverter-defibrillator pulse generator only with existing dual leads		Insertion of pacing cardioverter-defibrillator pulse generator only with existing multiple leads		Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system		Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system		Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system	
2		CMS	Staff												
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD				090		090		090		090		090		090
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA		102.0		102.0		102.0		102.0		102.0		102.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		60.0		60.0		60.0		60.0		60.0		60.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA		6.0		6.0		6.0		6.0		6.0		6.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA		36.0		36.0		36.0		36.0		36.0		36.0
9	PRE-SERVICE														
10	Start: Following visit when decision for surgery or procedure made														
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5		5		5		5		5		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		20		20		20		20		20		20
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		8		8		8		8		8		8
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		20		20		20		20		20		20
15	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA		7		7		7		7		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	L037D	RN/LPN/MTA		6		6		6		6		6		6
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	<i>List Number and Level of Office Visits</i>														
45	99211 16 minutes		16												
46	99212 27 minutes	L037D	27												
47	99213 36 minutes	L037D	36		1		1		1		1		1		1
48	99214 53 minutes		53												
49	99215 63 minutes		63												
50	99238 12 minutes		12												
51	Total Office Visit Time				36		36		36		36		36		36
52	Other Activity (please specify)														
53	End: with last office visit before end of global period				0		0		0		0		0		0
54	MEDICAL SUPPLIES														
55	pack, minimum multi-specialty visit	SA048	pack		2		2		2		2		2		2
56	pack, post-op incision care (suture)	SA054	kit		1		1		1		1		1		1
57	Equipment														
58	table, power	EF031	100%		36		36		36		36		36		36
59	light, exam	EQ168	100%		36		36		36		36		36		36

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment – Codes Reported Together 75% or More Screen

April 2011

Renal Angiography

In February 2010, CPT codes 75722 and 75724 were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These supervision and interpretation codes were commonly billed with the catheter placement code 36245. In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The panel deleted 75722 and 75724 and created four bundled services for RUC review in April 2011.

36251 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

The RUC reviewed the survey results from 70 physicians for CPT code 36251. The RUC reviewed the survey work values and agreed that the respondents overestimated the physician work value at the median level. The RUC compared the surveyed code to the recently valued reference code 31267 *Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus* (work RVU= 5.45) and agreed that the physician work and intensity is comparable with similar intra-service time of 45 minutes and 50 minutes, respectively. Given this, the RUC agreed that the work value for 36251 should be directly cross-walked to the work RVU of 5.45 for CPT code 31267. To further justify this value, the RUC compared the physician work of 36251 to the work of 52341 *Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 5.35 and intra time= 45 minutes) and agreed that while the surveyed code has less total time, 116 minutes compared to 135 minutes, 36251 is a more intense procedure and should be valued slightly higher than 52341. **The RUC recommends a work RVU of 5.45 for CPT code 36251.**

36252 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral

The RUC reviewed the survey results from 72 physicians for CPT code 36252. RUC reviewed the survey work values and agreed that the respondents overestimated the physician work value at the median level. The RUC compared the surveyed code to the reference code 43272 *Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique* (work RVU= 7.38) and agreed that the physician work and intensity is comparable with similar intra-service time of 53 minutes and 60 minutes, respectively. Given this, the RUC agreed that the work value for 36252 should be directly crosswalked to the work

RVU of 7.38 for the CPT code 43272. To further justify this value, the RUC compared the surveyed code to MPC code 58560 *Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)* (work RVU= 6.99) and agreed that while the reference code has greater intra-service time compared to 36252, 60 minutes and 53 minutes, the intensity and complexity of the physician work for the surveyed code is greater and should be valued higher than 58560. **The RUC recommends a work RVU of 7.38 for CPT code 36252.**

36253 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

The RUC reviewed the survey results from 66 physicians for CPT code 36253. The RUC reviewed the survey work values and agreed that the respondents overestimated the physician work value at the median level. The RUC compared the surveyed code to the reference code 52345 *Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)* (work RVU= 7.55) and agreed that the two services have comparable total time of 135 minutes and should be valued identically. Given this, the RUC recommends the physician work for 36253 be directly crosswalked to reference code 52345 for a work RVU of 7.55. To further justify this value, the RUC compared the surveyed code to the bilateral selective catheter placement code, 36252, and agreed that the increase in intensity and intra-service time, 60 minutes compared to 53 minutes, for code 36253 is accurately captured with a work RVU of 7.55 compared to 7.38 for 36252. **The RUC recommends a work RVU of 7.55 for CPT code 36253.**

36254 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral

The RUC reviewed the survey results from 66 physicians for CPT code 36253. The RUC reviewed the survey work values and agreed that the respondents overestimated the physician work value at the median level. The RUC compared the surveyed code to the recently reviewed reference code 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* (work RVU= 8.15) and agreed that the two services are comparable in physician work and intensity, with almost identical total time, 139 minutes and 138 minutes, respectively. Given this, the RUC recommends the physician work for 36254 be directly crosswalked to reference code 37220 for a work RVU of 8.15. To further justify this value, the RUC compared the surveyed code to the key reference service code 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS)* (work RVU= 7.99) and agreed that while the reference code has greater intra-service time, 77.5 minutes compared to 68 minutes, the respondents rated 36254 as a more intense procedure in the intensity and complexity measures. **The RUC recommends a work RVU of 8.15 for CPT code 36254.**

Work Neutrality

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

Practice Expense

The RUC reviewed the direct practice expense inputs recommended and made a few minor changes to the them to reflect the typical patient service. The RUC also noted that the standard of care now requires moderate sedation, which is inherent in the procedure. Apart from the additional RN time required to administer the moderate sedation, the practice expense recommendations create efficiencies.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
36245		Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	XXX	4.67 (No Change)
◎● 36251	V1	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	000	5.45
◎● 36252	V2	bilateral	000	7.38
◎● 36253	V3	Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (Do not report 36253 in conjunction with 36251 when performed for the same kidney)	000	7.55
◎● 36254	V4	bilateral (Do not report 36254 in conjunction with 36252) (Placement of closure device at the vascular access site is not separately reported for 36251-36254)	000	8.15

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
Radiology Diagnostic Radiology (Diagnostic Imaging) Vascular Procedures Aorta and Arteries				
D 75722		Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation <u>(75722 has been deleted. To report, see 36251, 36253)</u>	XXX	N/A
D 75724		Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation <u>(75724 has been deleted. To report, see 36252, 36254)</u>	XXX	N/A

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

CPT Code:36251 Tracking Number V1 Original Specialty Recommended RVU: **5.81**
Presented Recommended RVU: **5.81**
Global Period: 000 RUC Recommended RVU: **5.45**

CPT Descriptor: Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral
(Closure device placement at the vascular access site is not separately reported for 362X1-X4)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 63-year-old diabetic male with Stage II chronic kidney disease is being evaluated for uncontrolled hypertension. A renal duplex scan has shown an atrophic right kidney with no flow identified in the right renal artery. The left kidney is normal-sized, but the left renal artery is partially obscured by overlying bowel gas and could not be adequately seen. To limit exposure to contrast material, it was elected to perform a diagnostic catheter angiogram to further evaluate the renal arteries.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 97%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, the physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, and microcatheters that may be required, and ensures availability. Additional physician work includes: assess need for stand-by devices that might be needed emergently (eg, stents and covered stents), review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Also, reexamine patient to make sure that physical findings have not changed and update H&P; discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Administer or supervise administration of conscious sedation. The access vessel is palpated and local anesthesia is administered. Using Seldinger technique, the vessel is punctured, a guidewire is passed, and a flush catheter and guidewire are manipulated into the aorta. After forming the catheter, a small amount of contrast is injected to confirm appropriate and safe position. DSA imaging of the aorta and renal ostia is performed. After the non-selective imaging portion of the procedure is performed, the catheter is exchanged over guidewire for appropriate selective catheter which is manipulated under fluoroscopic guidance and formed in the aorta. The origin of the renal artery is probed for and ultimately engaged with the catheter advanced into the main renal. Sterile saline flush and test injection of contrast are performed to ensure intraluminal and safe position of catheter. Selective DSA imaging with injection of contrast or CO₂ is performed in multiple projections. If appropriate, pressure measurements are performed with withdrawal of catheter across the vessel origin. Several minutes of time may be dedicated to monitoring of pressure measurements, and wave forms with subsequent interpretation. The selective catheter is unformed under fluoroscopic observation in the thoracic aorta and subsequently removed. Manual compression or closure device are utilized for closure of the arteriotomy to achieve hemostasis.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, MD, Gerladine McGinty, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, David Han, MD, Michael Sutherland, MD, Mathew Sideman, MD				
Specialty(s):	Interventional Radiology, Radiology, Vascular Surgery and Cardiology				
CPT Code:	36251				
Sample Size:	2653	Resp N:	79	Response: 2.9 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	5.00	8.00	15.00
Survey RVW:		1.50	5.05	6.80	8.75
Pre-Service Evaluation Time:				45.00	
Pre-Service Positioning Time:				10.00	
Pre-Service Scrub, Dress, Wait Time:				10.00	
Intra-Service Time:		15.00	30.00	45.00	60.00
Immediate Post Service-Time:	30.00				
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
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:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36251	Recommended Physician Work RVU: 5.45		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		3.00	1.00	2.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		45.00		
Immediate Post Service-Time:	30.00			
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37224	000	9.00	RUC Time

CPT Descriptor Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34812	000	6.74	RUC Time	33,522

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
43260	000	5.95	RUC Time	13,234

CPT Descriptor 2 ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 13 **% of respondents:** 16.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 36251	<u>Key Reference CPT Code:</u> 37224	<u>Source of Time</u> RUC Time
Median Pre-Service Time	41.00	48.00	
Median Intra-Service Time	45.00	80.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	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	116.00	158.00	

Other time if appropriate		
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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	3.54	3.38
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	3.77
--	------	------

Urgency of medical decision making	3.54	3.31
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.92	3.92
--------------------------	------	------

Physical effort required	3.62	3.62
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.85	4.00
---	------	------

Outcome depends on the skill and judgment of physician	4.00	4.15
--	------	------

Estimated risk of malpractice suit with poor outcome	3.69	3.92
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.46	3.46
----------------------------------	------	------

Intra-Service intensity/complexity	3.69	3.85
------------------------------------	------	------

Post-Service intensity/complexity	3.62	3.54
-----------------------------------	------	------

Additional Rationale and Comments

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

CPT codes 36251-54 describe newly approved CPT codes for the performance of unilateral or bilateral renal selective and super-selective angiography. The CPT panel approved these bundled codes which now will include supervision and interpretation as inherent. The expert panel believes that magnitude estimation supports that the effort and total physician follows the CPT code order: The expert panel believes that the procedures are incrementally more difficult to perform and interpret.

A multi-specialty panel reviewed these codes and surveyed the membership of ACR, SIR, ACC, SCAI and SVS. RUC surveys were sent out electronically and then reviewed by our expert panel. The survey responses were excellent across these 4 codes as expected given the wide performance of these services.

The expert panel reviewed the survey data with attention given to frequency data for renal angiography based on the Medicare database. Renal angiography as indicated below is performed as a bilateral procedure approximately 4:1 when compared to its unilateral equivalent. In addition, the expert panel estimates that the first order bilateral selection procedure makes up approximately 85% of the bilateral claims. The expert panel recommendations will result in a positive budget neutrality, as shown in the table below.

In trying to interpret the data, maintain rank order, and respect budget neutrality, we believe that the most frequently reported code 36252 should act as the anchor code for which the other three codes.

When considering the work, an important anatomic fact must be understood: Renal arteries are **frequently multiple**—the incidence of any kidney having more than one vessel is about 25%. Most cases of multiple renal arteries are those having two per kidney, but three and even four arteries are described. Our survey respondents understand this anatomy and estimated work accordingly, but it is important to understand the numbers involved since each additional artery found involves an additional selective or superselective catheterization. In the old component coding scheme, these additional selections would have been coded with the appropriate multiple procedure discount applied. This would only add to the savings achieved when compared to the new coding scheme where no matter how many vessels are found and catheterized, the code is only billed once.

For example codes 36251 and 36253 involve unilateral catheterizations. Given an incidence of 25% and assuming *only* a single additional artery, there is therefore a 25% increase in the number of renal arteries requiring catheterization and in the work of all unilateral artery catheterization codes. This would still only be coded as ONE unilateral study.

For the bilateral codes 36252 and 36254, the work would be similarly increased by about 25%.

Code 36252 describes the bilateral selective renal artery first order catheterization and angiography. The survey data was similar between specialties with 72 multi-specialty surveys completed. The respondents indicated that the vignette was typical (99%). The most frequently chosen reference service was 37224-*endovascular repair of fem-pop with angioplasty* (intra time 80, RVU 9.00, IWPUT 0.092) followed by 37183 *TIPS revision* (intra time 78, RVU 7.99, IWPUT 0.086). The median intra service time reported in this strong survey was 53 minutes. The multi-specialty expert panel agree with the median time, and the median work RVU of 7.63. The table below summarizes reasonable cross-walks which support the time, recommended RVW and IWPUT for 362X2 with respect to other commonly performed endovascular procedures.

mpc	cpt code	long descriptor	glob day	work rvu	pre	intra time	post	total time	iwput	ruc mtg date
Yes	34812	Open femoral artery exposure for delivery of endovascular	000	6.74	75	45	30	150	0.098	Apr02
	37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	000	8.15	48	60	30	138	0.108	Apr10
Yes	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	000	5.95	20	46	20	86	0.110	Jun93
	52344	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	7.05	60	45	20	125	0.120	Feb-00
Yes	58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)	000	6.99	40	60	25	125	0.092	Apr97
	59076	Fetal shunt placement, including ultrasound guidance	000	8.99	105	60	0	165	0.114	Sept03
	93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) fo	000	7.35	48	50	30	128	0.113	Apr10

Code 36253 unilateral catheterization and super-selective renal angiography describes a more invasive deeper catheterization of the renal artery to either 2nd or 3rd order with the associated more detailed supervision and interpretation. Our survey request yielded 66 responses with median survey time of 60 minutes. The key reference service is 37183 *Tips revision* with 78 minutes and an RVU of 7.99. The multi-specialty expert panel felt that this time was appropriate, and that the corresponding median work RVU of 8.00 was also appropriate. The use of microcatheters into the renal arteries further supports the median times/RVUs.

36254 Bilateral catheterization and super-selective renal angiography represents the greatest total work and time of the 4 procedures. This is supported by our expert panel and the relative survey responses. Respondents (n=66) reported a median intra-time of 68 minutes, with the key reference service 37183 chosen as an appropriate reference service. The time and work RVUs are relatively

correct between the new code and the reference service. We recommend the median work RVU of 8.69. This value is appropriate and maintains the rank order of this family of codes internally as well as in the universe of endovascular procedures.

Code 36251 describes non-selective aortic angiography and unilateral selective renal angiography. The survey was strong with **79 respondents**. The vignette was deemed typical by 94%.

The median intra-service time was 45 minutes with a high degree of agreement across specialties. The most frequently chosen reference service was 37224-*endovascular repair of fem-pop with angioplasty* (intra time 80, RVU 9.00, IWPUT 0.092) followed by 37183 *TIPS revision* (intra time 78, RVU 7.99, IWPUT 0.086). This was the one code in this new family of four codes that presented a challenge as the median survey RVU of 6.80 with corresponding IWPUT of 0.107 was, in our opinion, not correct relative to other endovascular procedures and the 25% RVU of 5.05 with corresponding IWPUT of 0.078 was also not correct compared with other endovascular procedures. Our expert panel agreed that the correct value for total physician work was somewhere between the 25th percentile and the median work RVU. It was further agreed that maintaining internal rank order amongst the four codes in the family was important.

Based on our recommendations that maintain an appropriate rank order, the **family of four codes** would have the following times, work RVUs, and IWPUTs while ensuring budget neutrality when the family is compared to the current coding methodology and values.

cpt code	Descriptor	glob day	work rvu	pre	Intra time	post	total time	
36251	<i>1st order unilateral</i>	000	5.45	43	45	30	116	
36252	<i>1st order bilateral</i>	000	7.38	43	53	30	124	
36253	<i>2nd order unilateral</i>	000	7.55	43	60	30	131	
36254	<i>2nd order bilateral</i>	000	8.15	43	68	30	139	

SERVICES REPORTED WITH MULTIPLE CPT CODES

- 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)

- 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. Numerous other diagnostic studies and/or interventions may be reported on the same date of service, but these are highly variable.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 36245 and 75722

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

CPT Code:36252 Tracking Number V2 Original Specialty Recommended RVU: **7.63**
Presented Recommended RVU: **7.63**
Global Period: 000 RUC Recommended RVU: **7.38**

CPT Descriptor: Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral
(Closure device placement at the vascular access site is not separately reported for 362X1-X4)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 80-year-old female with Stage III chronic kidney disease and hypertension, which requires three medications to control, is being evaluated for renal artery stenosis. A magnetic resonance angiography was done which suggested there may be ostial stenosis of the right main renal artery and possible stenosis of the origin of the left renal artery. Diagnostic bilateral renal catheter arteriogram is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 97%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, the physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, and microcatheters that may be required, and ensure availability. Additional physician work includes: assess need for stand-by devices that might be needed emergently (eg, stents and covered stents), review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Also, reexamine patient to make sure that physical findings have not changed and update H&P; discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Administer or supervise administration of conscious sedation. The access vessel is palpated and local anesthesia is administered. Using Seldinger technique, the vessel is punctured, a guidewire is passed, and a flush catheter and guidewire are manipulated into the aorta. After forming the catheter, a small amount of contrast is injected to confirm appropriate and safe position. DSA imaging of the aorta and renal ostia is performed. After the non-selective imaging portion of the procedure is performed, the catheter is exchanged over guidewire for appropriate selective catheter which is manipulated under fluoroscopic guidance and formed in the aorta. The origin of the renal artery is probed for and ultimately engaged. Sterile saline flush and test injection of contrast are performed to ensure intraluminal and safe position of catheter. Selective DSA imaging with injection of contrast or CO₂ is performed in multiple projections. If appropriate, pressure measurements are performed with withdrawal of catheter across the vessel origin. Several minutes of time may be dedicated to monitoring of pressure measurements, and wave forms with subsequent interpretation. The selective catheter is advanced out of the renal artery and the contralateral renal artery is probed for and ultimately selected. Repeat test injection, DSA imaging and pressure measurements are performed as described on the initial side. The selective catheter is unformed under fluoroscopic observation in the thoracic aorta and subsequently removed. Manual compression or closure device are utilized for closure of the arteriotomy to achieve hemostasis.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, MD, Gerladine McGinty, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, David Han, MD, Michael Sutherland, MD, Mathew Sideman, MD				
Specialty(s):	Interventional Radiology, Radiology, Vascular Surgery and Cardiology				
CPT Code:	36252				
Sample Size:	2653	Resp N:	72	Response: 2.7 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	4.00	6.00	15.00
Survey RVW:		1.80	5.37	7.63	9.06
Pre-Service Evaluation Time:				45.00	
Pre-Service Positioning Time:				10.00	
Pre-Service Scrub, Dress, Wait Time:				10.00	
Intra-Service Time:		15.00	40.00	53.00	75.00
Immediate Post Service-Time:	30.00				
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
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:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36252	Recommended Physician Work RVU: 7.38		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		3.00	1.00	2.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		53.00		
Immediate Post Service-Time:	30.00			
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
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Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37224	000	9.00	RUC Time

CPT Descriptor Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34812	000	6.74	RUC Time	33,522

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
43260	000	5.95	RUC Time	13,234

CPT Descriptor 2 ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 14 **% of respondents:** 17.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 36252	<u>Key Reference CPT Code:</u> 37224	<u>Source of Time</u> RUC Time
Median Pre-Service Time	41.00	48.00	
Median Intra-Service Time	53.00	80.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
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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	124.00	158.00	

Other time if appropriate		
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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	3.71	3.43
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.07	3.93
--	------	------

Urgency of medical decision making	3.36	3.29
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.07	4.00
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Physical effort required	3.57	3.57
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.07	4.07
---	------	------

Outcome depends on the skill and judgment of physician	4.14	4.14
--	------	------

Estimated risk of malpractice suit with poor outcome	3.79	3.93
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.71	3.50
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	3.93
------------------------------------	------	------

Post-Service intensity/complexity	3.71	3.79
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Additional Rationale and Comments

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Code 36251 describes non-selective aortic angiography and unilateral selective renal angiography. The survey was strong with **79 respondents**. The vignette was deemed typical by 94%.

The median intra-service time was 45 minutes with a high degree of agreement across specialties. The most frequently chosen reference service was 37224-*endovascular repair of fem-pop with angioplasty* (intra time 80, RVU 9.00, IWP/UT 0.092) followed by 37183 *TIPS revision* (intra time 78, RVU 7.99, IWP/UT 0.086). This was the one code in this new family of four codes that presented a challenge as the median survey RVU of 6.80 with corresponding IWP/UT of 0.107 was, in our opinion, not correct relative to other endovascular procedures and the 25% RVU of 5.05 with corresponding IWP/UT of 0.078 was also not correct compared with other endovascular procedures. Our expert panel agreed that the correct value for total physician work was somewhere between the 25th percentile and the median work RVU. It was further agreed that maintaining internal rank order amongst the four codes in the family was important.

Our multi-disciplinary expert panel considered the work of catheterizing the renal artery and performing angiography and agreed that the typical patient, severity of disease, physician work, and intensity of physician work has not changed over time (ie, no compelling evidence). In order to maintain rank order in this family of codes, we recommend an RVU of 5.81 which is the sum of the current codes used to report this procedure (36245+75722).

Based on our recommendations that maintain an appropriate rank order, the **family of four codes** would have the following times, work RVUs, and IWP/UTs while ensuring budget neutrality when the family is compared to the current coding methodology and values.

cpt code	Descriptor	glob day	work rvu	pre	Intra time	post	total time	
36251	<i>1st order unilateral</i>	000	5.45	43	45	30	116	
36252	<i>1st order bilateral</i>	000	7.38	43	53	30	124	
36253	<i>2nd order unilateral</i>	000	7.55	43	60	30	131	
36254	<i>2nd order bilateral</i>	000	8.15	43	68	30	139	

SERVICES REPORTED WITH MULTIPLE CPT CODES

- 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)

- 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. Numerous other diagnostic studies and/or interventions may be reported on the same date of service, but these are highly variable.

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

CPT Code:36253 Tracking Number V3 Original Specialty Recommended RVU: **8.00**
Presented Recommended RVU: **8.00**
Global Period: 000 RUC Recommended RVU: **7.55**

CPT Descriptor: Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (Closure device placement at the vascular access site is not separately reported for 36251-54)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female presents with acute onset of hematuria. She recently had a left renal biopsy performed for chronic kidney disease evaluation.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 98%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, the physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, and microcatheters that may be required, and ensure availability. Additional physician work includes: assess need for stand-by devices that might be needed emergently (eg, stents and covered stents), review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Also, reexamine patient to make sure that physical findings have not changed and update H&P; discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Administer or supervise administration of conscious sedation. The access vessel is palpated and local anesthesia is administered. Using Seldinger technique, the vessel is punctured, a guidewire is passed,

and a flush catheter and guidewire are manipulated into the aorta. After forming the catheter, a small amount of contrast is injected to confirm appropriate and safe position. DSA imaging of the aorta and renal ostia is performed. After the non-selective imaging portion of the procedure is performed, the catheter is exchanged over guidewire for appropriate selective catheter which is manipulated under fluoroscopic guidance and formed in the aorta. The origin of the renal artery is probed for and ultimately engaged. Sterile saline flush and test injection of contrast are performed to ensure intraluminal and safe position of catheter. Selective DSA imaging with injection of contrast or CO₂ is performed in multiple projections. A second microcatheter is prepared on the back sterile table with assistant. Through the base catheter, this microcatheter and wire are introduced into the base catheter with sterile pressurized heparin flush connected and infused. Using careful fluoroscopic guidance, alternating wire and catheter maneuvers are performed, and the microcatheter is advanced into the second or third order branch vessel of the renal artery. Magnification DSA imaging using contrast or CO₂ is performed in multiple projections. The microcatheter is withdrawn and the base catheter is unformed under fluoroscopic observation in the thoracic aorta and subsequently removed. Manual compression or closure device are utilized for closure of the arteriotomy to achieve hemostasis.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, MD, Gerladine McGinty, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, David Han, MD, Michael Sutherland, MD, Mathew Sideman, MD				
Specialty(s):	Interventional Radiology, Radiology, Vascular Surgery and Cardiology				
CPT Code:	36253				
Sample Size:	2653	Resp N:	66	Response: 2.4 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	1.00	4.00	10.00
Survey RVW:		2.20	6.06	8.00	9.94
Pre-Service Evaluation Time:				48.00	
Pre-Service Positioning Time:				10.00	
Pre-Service Scrub, Dress, Wait Time:				10.00	
Intra-Service Time:		20.00	40.00	60.00	75.00
Immediate Post Service-Time:	30.00				
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
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:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36253	Recommended Physician Work RVU: 7.55		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		3.00	1.00	2.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	30.00			
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37183	000	7.99	RUC Time

CPT Descriptor Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34812	000	6.74	RUC Time	33,522

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
43260	000	5.95	RUC Time	13,234

CPT Descriptor 2 ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 11 **% of respondents:** 13.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 36253	<u>Key Reference CPT Code:</u> 37183	<u>Source of Time</u> RUC Time
Median Pre-Service Time	41.00	27.50	
Median Intra-Service Time	60.00	77.50	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	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	131.00	135.00
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	3.64
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.09	3.73
--	------	------

Urgency of medical decision making	4.45	3.64
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.36	3.91
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Physical effort required	4.27	3.91
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.18	3.82
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Outcome depends on the skill and judgment of physician	4.45	3.91
--	------	------

Estimated risk of malpractice suit with poor outcome	4.36	3.91
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.73	3.73
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Intra-Service intensity/complexity	4.27	4.00
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Post-Service intensity/complexity	3.64	3.73
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Additional Rationale and Comments

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

CPT codes 36251-54 describe newly approved CPT codes for the performance of unilateral or bilateral renal selective and super-selective angiography. The CPT panel approved these bundled codes which now will include supervision and interpretation as inherent. The expert panel believes that magnitude estimation supports that the effort and total physician follows the CPT code

order: 36251 < 36252 < 36253 < 36254. The expert panel believes that the procedures are incrementally more difficult to perform and interpret.

A multi-specialty panel reviewed these codes and surveyed the membership of ACR, SIR, ACC, SCAI and SVS. RUC surveys were sent out electronically and then reviewed by our expert panel. The survey responses were excellent across these 4 codes as expected given the wide performance of these services.

The expert panel reviewed the survey data with attention given to frequency data for renal angiography based on the Medicare database. Renal angiography as indicated below is performed as a bilateral procedure approximately 4:1 when compared to its unilateral equivalent. In addition, the expert panel estimates that the first order bilateral selection procedure makes up approximately 85% of the bilateral claims. The expert panel recommendations will result in a positive budget neutrality, as shown in the table below.

In trying to interpret the data, maintain rank order, and respect budget neutrality, we believe that the most frequently reported code 36252 should act as the anchor code for which the other three codes.

When considering the work, an important anatomic fact must be understood: Renal arteries are **frequently multiple**—the incidence of any kidney having more than one vessel is about 25%. Most cases of multiple renal arteries are those having two per kidney, but three and even four arteries are described. Our survey respondents understand this anatomy and estimated work accordingly, but it is important to understand the numbers involved since each additional artery found involves an additional selective or superselective catheterization. In the old component coding scheme, these additional selections would have been coded with the appropriate multiple procedure discount applied. This would only add to the savings achieved when compared to the new coding scheme where no matter how many vessels are found and catheterized, the code is only billed once.

For example codes 36251 and 36253 involve unilateral catheterizations. Given an incidence of 25% and assuming *only* a single additional artery, there is therefore a 25% increase in the number of renal arteries requiring catheterization and in the work of all unilateral artery catheterization codes. This would still only be coded as ONE unilateral study.

For the bilateral codes 36252 and 36254, the work would be similarly increased by about 25%.

Code 36252 describes the bilateral selective renal artery first order catheterization and angiography. The survey data was similar between specialties with 72 multi-specialty surveys completed. The respondents indicated that the vignette was typical (99%). The most frequently chosen reference service was 37224-*endovascular repair of fem-pop with angioplasty* (intra time 80, RVU 9.00, IWP/UT 0.092) followed by 37183 *TIPS revision* (intra time 78, RVU 7.99, IWP/UT 0.086). The median intra service time reported in this strong survey was 53 minutes. The multi-specialty expert panel agree with the median time, and the median work RVU of 7.63. The table below summarizes reasonable cross-walks which support the time, recommended RVW and IWP/UT for 36252 with respect to other commonly performed endovascular procedures.

mpc	cpt code	long descriptor	glob day	work rvu	pre	intra time	post	total time	iwput	ruc mtg date
Yes	34812	Open femoral artery exposure for delivery of endovascular	000	6.74	75	45	30	150	0.098	Apr02
	37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	000	8.15	48	60	30	138	0.108	Apr10
Yes	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	000	5.95	20	46	20	86	0.110	Jun93
	52344	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	7.05	60	45	20	125	0.120	Feb-00
Yes	58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)	000	6.99	40	60	25	125	0.092	Apr97
	59076	Fetal shunt placement, including ultrasound guidance	000	8.99	105	60	0	165	0.114	Sept03
	93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) fo	000	7.35	48	50	30	128	0.113	Apr10

Code 36253 unilateral catheterization and super-selective renal angiography describes a more invasive deeper catheterization of the renal artery to either 2nd or 3rd order with the associated more detailed supervision and interpretation. Our survey request yielded 66 responses with median survey time of 60 minutes. The key reference service is 37183 *Tips revision* with 78 minutes and an RVU of 7.99. The use of microcatheters into the renal arteries further supports the median times/RVUs.

36254 Bilateral catheterization and super-selective renal angiography represents the greatest total work and time of the 4 procedures. This is supported by our expert panel and the relative survey responses. Respondents (n=66) reported a median intra-time of 68 minutes, with the key reference service 37183 chosen as an appropriate reference service. The time and work RVUs are relatively

correct between the new code and the reference service. We recommend the median work RVU of 8.69. This value is appropriate and maintains the rank order of this family of codes internally as well as in the universe of endovascular procedures.

Code 36251 describes non-selective aortic angiography and unilateral selective renal angiography. The survey was strong with **79 respondents**. The vignette was deemed typical by 94%.

The median intra-service time was 45 minutes with a high degree of agreement across specialties. The most frequently chosen reference service was 37224-*endovascular repair of fem-pop with angioplasty* (intra time 80, RVU 9.00, IWPUT 0.092) followed by 37183 *TIPS revision* (intra time 78, RVU 7.99, IWPUT 0.086). This was the one code in this new family of four codes that presented a challenge as the median survey RVU of 6.80 with corresponding IWPUT of 0.107 was, in our opinion, not correct relative to other endovascular procedures and the 25% RVU of 5.05 with corresponding IWPUT of 0.078 was also not correct compared with other endovascular procedures. Our expert panel agreed that the correct value for total physician work was somewhere between the 25th percentile and the median work RVU. It was further agreed that maintaining internal rank order amongst the four codes in the family was important.

Our multi-disciplinary expert panel considered the work of catheterizing the renal artery and performing angiography and agreed that the typical patient, severity of disease, physician work, and intensity of physician work has not changed over time (ie, no compelling evidence). In order to maintain rank order in this family of codes, we recommend an RVU of 5.81 which is the sum of the current codes used to report this procedure (36245+75722).

Based on our recommendations that maintain an appropriate rank order, the **family of four codes** would have the following times, work RVUs, and IWPUTs while ensuring budget neutrality when the family is compared to the current coding methodology and values.

cpt code	Descriptor	glob day	work rvu	pre	Intra time	post	total time	iwput
36251	<i>1st order unilateral</i>	000	5.45	43	45	30	116	0.095
36252	<i>1st order bilateral</i>	000	7.38	43	53	30	124	0.115
36253	<i>2nd order unilateral</i>	000	7.55	43	60	30	131	0.108
36254	<i>2nd order bilateral</i>	000	8.15	43	68	30	139	0.105

SERVICES REPORTED WITH MULTIPLE CPT CODES

- 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)

- 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. Numerous other diagnostic studies and/or interventions may be reported on the same date of service.

FREQUENCY INFORMATION

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

CPT Code:36254 Tracking Number V4 Original Specialty Recommended RVU: **8.69**
Presented Recommended RVU: **8.69**
Global Period: 000 RUC Recommended RVU: **8.15**

CPT Descriptor: Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral

(Closure device placement at the vascular access site is not separately reported for 36251-54)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male is undergoing evaluation for hypertension. Renal duplex scanning and computed tomographic angiography have identified branch renal artery aneurysms bilaterally. Renal arteriography is ordered to get more detailed anatomy of the aneurysms to plan repair.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 98%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings and pre-procedural studies, the physician estimates the range of guiding catheters, selective catheters, sheaths, guidewires, and microcatheters that may be required, and ensure availability. Additional physician work includes: assess need for stand-by devices that might be needed emergently (eg, stents and covered stents), review results of preadmission testing, with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Also, reexamine patient to make sure that physical findings have not changed and update H&P; discuss procedure detail plan, including alternatives and risks with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access sites. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Supervise sterile prep of access site(s) and subsequent draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Administer or supervise administration of conscious sedation. The access vessel is palpated and local anesthesia is administered. Using Seldinger technique, the vessel is punctured, a guidewire is passed, and a flush catheter and guidewire are manipulated into the aorta. After forming the catheter, a small amount of contrast is injected to confirm appropriate and safe position. DSA imaging of the aorta and renal ostia is performed. After the non-selective imaging portion of the procedure is performed, the catheter is exchanged over guidewire for appropriate selective catheter which is manipulated under fluoroscopic guidance and formed in the aorta. The origin of the renal artery is probed for and ultimately engaged. Sterile saline flush and test injection of contrast are performed to ensure intraluminal and safe position of catheter. Selective DSA imaging with injection of contrast or CO₂ is performed in multiple projections. If appropriate, pressure measurements are performed with withdrawal of catheter across the vessel origin. Several minutes of time may be dedicated to monitoring of pressure measurements, and wave forms with subsequent interpretation. A second microcatheter is prepared on the back sterile table with assistant. Through the base catheter, this microcatheter and wire are introduced into the base catheter with sterile pressurized heparin flush connected and infused. Using careful fluoroscopic guidance, alternating wire and catheter maneuvers are performed, and the microcatheter is advanced into the second or third order branch vessel of the renal artery. Magnification DSA imaging using contrast or CO₂ is performed in multiple projections. The microcatheter is withdrawn and the selective catheter is advanced out of the renal artery and the contralateral renal artery is probed for and ultimately selected. Repeat test injection, DSA imaging and pressure measurements are performed as described on the initial side. The microcatheter is prepped and re-advanced through the base catheter, and using guidance, the contralateral second or third order branches are selected with repeat magnification imaging performed as indicated. The base catheter is unformed under fluoroscopic observation in the thoracic aorta and subsequently removed. Manual compression or closure device are utilized for closure of the arteriotomy to achieve hemostasis.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs and perfusion of treated limb multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). Write orders for follow-up labs, x-rays. All appropriate medical records are completed, with copy to referring physician.

Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, x-rays, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, MD, Gerladine McGinty, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, David Han, MD, Michael Sutherland, MD, Mathew Sideman, MD				
Specialty(s):	Interventional Radiology, Radiology, Vascular Surgery and Cardiology				
CPT Code:	36254				
Sample Size:	2653	Resp N:	66	Response: 2.4 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	1.00	3.00	8.00
Survey RVW:		2.30	7.05	8.69	10.43
Pre-Service Evaluation Time:				50.00	
Pre-Service Positioning Time:				10.00	
Pre-Service Scrub, Dress, Wait Time:				10.00	
Intra-Service Time:		20.00	53.00	68.00	90.00
Immediate Post Service-Time:	30.00				
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
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:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	36254	Recommended Physician Work RVU: 8.15		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		3.00	1.00	2.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		68.00		
Immediate Post Service-Time:	30.00			
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37183	000	7.99	RUC Time

CPT Descriptor Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34812	000	6.74	RUC Time	33,522

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
43260	000	5.95	RUC Time	13,234

CPT Descriptor 2 ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 11 **% of respondents:** 13.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 36254	<u>Key Reference CPT Code:</u> 37183	<u>Source of Time</u> RUC Time
Median Pre-Service Time	41.00	27.50	
Median Intra-Service Time	68.00	77.50	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	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	139.00	135.00
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	4.36	3.36
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.73
--	------	------

Urgency of medical decision making	3.27	3.55
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.27	4.09
--------------------------	------	------

Physical effort required	4.18	4.09
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	3.55
---	------	------

Outcome depends on the skill and judgment of physician	4.36	4.09
--	------	------

Estimated risk of malpractice suit with poor outcome	4.09	3.64
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.91	3.91
----------------------------------	------	------

Intra-Service intensity/complexity	4.27	4.09
------------------------------------	------	------

Post-Service intensity/complexity	3.55	3.55
-----------------------------------	------	------

Additional Rationale and Comments

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

CPT codes 36251-54 describe newly approved CPT codes for the performance of unilateral or bilateral renal selective and super-selective angiography. The CPT panel approved these bundled codes which now will include supervision and interpretation as inherent. The expert panel believes that magnitude estimation supports that the effort and total physician follows the CPT code

order: 36251 < 36252 < 36253 < 36254. The expert panel believes that the procedures are incrementally more difficult to perform and interpret.

A multi-specialty panel reviewed these codes and surveyed the membership of ACR, SIR, ACC, SCAI and SVS. RUC surveys were sent out electronically and then reviewed by our expert panel. The survey responses were excellent across these 4 codes as expected given the wide performance of these services.

The expert panel reviewed the survey data with attention given to frequency data for renal angiography based on the Medicare database. Renal angiography as indicated below is performed as a bilateral procedure approximately 4:1 when compared to its unilateral equivalent. In addition, the expert panel estimates that the first order bilateral selection procedure makes up approximately 85% of the bilateral claims. The expert panel recommendations will result in a positive budget neutrality, as shown in the table below.

In trying to interpret the data, maintain rank order, and respect budget neutrality, we believe that the most frequently reported code 36252 should act as the anchor code for which the other three codes.

When considering the work, an important anatomic fact must be understood: Renal arteries are **frequently multiple**—the incidence of any kidney having more than one vessel is about 25%. Most cases of multiple renal arteries are those having two per kidney, but three and even four arteries are described. Our survey respondents understand this anatomy and estimated work accordingly, but it is important to understand the numbers involved since each additional artery found involves an additional selective or superselective catheterization. In the old component coding scheme, these additional selections would have been coded with the appropriate multiple procedure discount applied. This would only add to the savings achieved when compared to the new coding scheme where no matter how many vessels are found and catheterized, the code is only billed once.

For example codes 36251 and 36253 involve unilateral catheterizations. Given an incidence of 25% and assuming *only* a single additional artery, there is therefore a 25% increase in the number of renal arteries requiring catheterization and in the work of all unilateral artery catheterization codes. This would still only be coded as ONE unilateral study. For the bilateral codes 36252 and 36254, the work would be similarly increased by about 25%.

Code 36252 describes the bilateral selective renal artery first order catheterization and angiography. The survey data was similar between specialties with 72 multi-specialty surveys completed. The respondents indicated that the vignette was typical (99%). The most frequently chosen reference service was 37224-*endovascular repair of fem-pop with angioplasty* (intra time 80, RVU 9.00, IWPUT 0.092) followed by 37183 *TIPS revision* (intra time 78, RVU 7.99, IWPUT 0.086). The median intra service time reported in this strong survey was 53 minutes. The multi-specialty expert panel agree with the median time, and the median work RVU of 7.63. The table below summarizes reasonable cross-walks which support the time, recommended RVW and IWPUT for 36252 with respect to other commonly performed endovascular procedures.

mpc	cpt code	long descriptor	glob day	work rvu	pre	intra time	post	total time	iwput	ruc mtg date
Yes	34812	Open femoral artery exposure for delivery of endovascular	000	6.74	75	45	30	150	0.098	Apr02
	37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	000	8.15	48	60	30	138	0.108	Apr10
Yes	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	000	5.95	20	46	20	86	0.110	Jun93
	52344	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	000	7.05	60	45	20	125	0.120	Feb-00
Yes	58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)	000	6.99	40	60	25	125	0.092	Apr97
	59076	Fetal shunt placement, including ultrasound guidance	000	8.99	105	60	0	165	0.114	Sept03
	93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) fo	000	7.35	48	50	30	128	0.113	Apr10

Code 36253 unilateral catheterization and super-selective renal angiography describes a more invasive deeper catheterization of the renal artery to either 2nd or 3rd order with the associated more detailed supervision and interpretation. Our survey request yielded 66 responses with median survey time of 60 minutes. The key reference service is 37183 *Tips revision* with 78 minutes and an RVU of 7.99. The multi-specialty expert panel felt that this time was appropriate, and that the corresponding median work RVU of 8.00 was also appropriate. The use of microcatheters into the renal arteries further supports the median times/RVUs.

36254 Bilateral catheterization and super-selective renal angiography represents the greatest total work and time of the 4 procedures. This is supported by our expert panel and the relative survey responses. Respondents (n=66) reported a median intra-time of 68

minutes, with the key reference service 37183 chosen as an appropriate reference service. The time and work RVUs are relatively correct between the new code and the reference service.

Code 36251 describes non-selective aortic angiography and unilateral selective renal angiography. The survey was strong with **79 respondents**. The vignette was deemed typical by 94%.

The median intra-service time was 45 minutes with a high degree of agreement across specialties. The most frequently chosen reference service was 37224-*endovascular repair of fem-pop with angioplasty* (intra time 80, RVU 9.00, IWP/UT 0.092) followed by 37183 *TIPS revision* (intra time 78, RVU 7.99, IWP/UT 0.086). This was the one code in this new family of four codes that presented a challenge as the median survey RVU of 6.80 with corresponding IWP/UT of 0.107 was, in our opinion, not correct relative to other endovascular procedures and the 25% RVU of 5.05 with corresponding IWP/UT of 0.078 was also not correct compared with other endovascular procedures. Our expert panel agreed that the correct value for total physician work was somewhere between the 25th percentile and the median work RVU. It was further agreed that maintaining internal rank order amongst the four codes in the family was important.

Our multi-disciplinary expert panel considered the work of catheterizing the renal artery and performing angiography and agreed that the typical patient, severity of disease, physician work, and intensity of physician work has not changed over time (ie, no compelling evidence). In order to maintain rank order in this family of codes, we recommend an RVU of 5.81 which is the sum of the current codes used to report this procedure (36245+75722).

Based on our recommendations that maintain an appropriate rank order, the **family of four codes** would have the following times, work RVUs, and IWP/UTs while ensuring budget neutrality when the family is compared to the current coding methodology and values.

cpt code	Descriptor	glob day	work rvu	pre	Intra time	post	total time	
36251	<i>1st order unilateral</i>	000	5.45	43	45	30	116	
36252	<i>1st order bilateral</i>	000	7.38	43	53	30	124	
36253	<i>2nd order unilateral</i>	000	7.55	43	60	30	131	
36254	<i>2nd order bilateral</i>	000	8.15	43	68	30	139	

SERVICES REPORTED WITH MULTIPLE CPT CODES

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

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

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

- 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. Numerous other diagnostic studies and/or interventions may be reported on the same date of service.

FREQUENCY INFORMATION

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

CPT Long Descriptors:

●36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral*

●36252 *bilateral*

●36253 *Supers elective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral*

(Do not report 36253 in conjunction with 36251 when performed for the same kidney)

●36254 *bilateral*

(Do not report 36254 in conjunction with 36252)

(Closure device placement at the vascular access site is not separately reported for 36251-54)

Global Periods: 000

Meeting Date: April 2011

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

The multispecialty organizations (SIR, ACR, SVS, ACC and SCAI) convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for these newly created CPT codes.

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

We selected CPT code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty* as our comparison code. The procedures, processes and resources are comparable. CPT code 37224 was recently RUC'ed/PEAC'ed (April 2010).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Phone calls & prescriptions
- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

The patient is greeted, gowning is provided and patient is escorted to procedure room. The nurse obtains vital signs, interviews the patient for allergies, medications and coagulopathy. Procedure is explained and informed consent is witnessed. The rad tech prepares the room, equipment and supplies after consulting with the M.D regarding the supplies to be used. The angio tech prepares the back table. IV access is established. The patient is positioned, skin is prepped and the patient is draped. RN administers conscious sedation. The angio tech assists the M.D. performing procedure. The rad tech assists the MD with flouro, contrast, image acquisition, etc. The patient is escorted to the observation area. RN performs sequential vital signs over 4 hour observation. RT processes the images and completes all the necessary paperwork. The angio tech cleans the room. The patient is given discharge instructions.

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

AMA/Specialty Society RVS Update Committee Recommendation

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

CPT Long Descriptors:

●36251 *Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral*

●36252 *bilateral*

●36253 *Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral*

(Do not report 36253 in conjunction with 36251 when performed for the same kidney)

●36254 *bilateral*

(Do not report 36254 in conjunction with 36252)

(Closure device placement at the vascular access site is not separately reported for 36251-54)

Global Periods: 000

Meeting Date: April 2011

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

The multispecialty organizations (SIR, ACR, SVS, ACC and SCAI) convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for these newly created CPT codes.

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

We selected CPT code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty* as our comparison code. The procedures, processes and resources are comparable. CPT code 37224 was recently RUC'ed/PEAC'ed (April 2010).

AMA/Specialty Society RVS Update Committee Recommendation

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				37224		36251		36252		36253		36254	
2	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation	CMS	Staff	Fem/Pop PTA Approved April 2010		Selective catheter placement (first-order); unilateral		Selective catheter placement (first-order); bilateral		Superselective catheter placement; unilateral		Superselective catheter placement; bilateral	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000
5	TOTAL CLINICAL LABOR TIME			358	9	251	9	275	9	296	9	320	9
6		RN L051A	RN	142		107		115		122		130	
7		RN/LPN/MTA L037D	RN/LPN/MTA	50	9	39	9	41	9	43	9	45	9
8		Angio Tech L041A	AngioTech	91		59		67		74		82	
9		Rad Tech L041B	Rad Tech	75		46		52		57		63	
10	TOTAL PRE-SERV CLINICAL LABOR TIME			15	6	15	6	15	6	15	6	15	6
11	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			340	0	233	0	257	0	278	0	302	0
12	TOTAL POST-SERV CLINICAL LABOR TIME			3	3	3	3	3	3	3	3	3	3
13	PRE-SERVICE												
14	Start: Following visit when decision for surgery or procedure made												
15	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3
16	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		3		3		3		3	
17	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3		3
18	Provide pre-service education/obtain consent												
19	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3		3		3		3		3	
20	Other Clinical Activity (please specify): Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD	L041A	AngioTech	6		6		6		6		6	
21	End: When patient enters office/facility for surgery/procedure												
22	SERVICE PERIOD												
23	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure												
24	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	5		3		3		3		3	
25	Obtain vital signs	L037D	RN/LPN/MTA	5		5		5		5		5	
26	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5		5		5		5	
27	Prepare room, equipment, supplies (including imaging equipment)	L041B	Rad Tech	7		7		7		7		7	
28	Setup scope (non facility setting only)												
29	Prepare and position patient/ monitor patient/ set up IV	L041B	Rad Tech	5		5		5		5		5	
30	Sedate/apply anesthesia	L051A	RN	2		2		2		2		2	
31	Intra-service												
32	Assist physician in performing procedure	L041A	AngioTech	80		45		53		60		68	
33	Assist physician in performing procedure (CS)	L051A	RN	80		45		53		60		68	
34	Assisting with flouroscopy/image acquisition (75%)	L041B	Rad Tech	60		34		40		45		51	
35	Circulating throughout procedure (25%)	L037D	RN/LPN/MTA	20		11		13		15		17	
36	Image Post Processing	L041A	AngioTech	5		5		5		5		5	
37	Post-Service												
38	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60		60		60		60		60	
39	Clean room/equipment by physician staff	L041A	AngioTech	3		3		3		3		3	
40	Clean Scope												
41	Clean Surgical Instrument Package												
42	Complete diagnostic forms, lab & X-ray requisitions												

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				37224		36251		36252		36253		36254	
2	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation	CMS	Staff	Fem/Pop PTA Approved April 2010		Selective catheter placement (first-order); unilateral		Selective catheter placement (first-order); bilateral		Superselective catheter placement; unilateral		Superselective catheter placement; bilateral	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
43	Review/read X-ray, lab, and pathology reports												
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3		3		3		3	
45	Discharge day management												
46	Other Clinical Activity (please specify)												
47	End: Patient leaves office												
48	POST-SERVICE Period												
49	Start: Patient leaves office/facility												
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3
51	Office visits: None												
59	Total Office Visit Time			0	0	0	0	0	0	0	0	0	0
60	Other Activity (please specify)												
61	End: with last office visit before end of global period				0		0		0		0		0
62	MEDICAL SUPPLIES		Unit										
63	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1	
64	pack, conscious sedation	SA044	pack	1		1		1		1		1	
65	gown, surgical, sterile	SB028	item	2		2		2		2		2	
66	gloves, sterile	SB024	pair	2		2		2		2		2	
67	mask, surgical, with face shield	SB034	item	4		4		4		4		4	
68	cap, surgical	SB001	item	4		4		4		4		4	
69	shoe covers, surgical	SB039	pair	4		4		4		4		4	
70	tray, shave prep	SA067	tray	1		1		1		1		1	
71	underpad 2ftx3ft (Chux)	SB044	item	1		1		1		1		1	
72	drape, sterile, femoral	SB009	item	1		1		1		1		1	
73	drape-towel, sterile 18inx26in	SB019	item	4		4		4		4		4	
74	Betadine	SJ041	ml	60		60		60		60		60	
75	applicator, sponge-tipped	SG009	item	4		4		4		4		4	
76	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10		10		10		10		10	
77	syringe 10-12 ml	SC051	item	4		4		4		4		4	
78	syringe, 20 cc	SC053	item	4		4		4		4		4	
79	sodium chloride 0.9% flush syringe	SH065	item	2		2		2		2		2	
80	closed flush system, angiography	SC010	item	1		1		1		1		1	
81	blade, surgical (Bard-Parker)	SF007	item	1		1		1		1		1	
82	steri-strip (6 strip uou)	SG074	item	1		1		1		1		1	
83	guidewire bowl w-lid, sterile	SD171	item	2		2		2		2		2	
84	gauze, sterile 4in x 4in	SG056	item	2		2		2		2		2	
85	dressing 3 X 4 wound care telfa	SG035	item	2		2		2		2		2	
86	drape, sterile, c-arm, fluoro	SB008	item	1		1		1		1		1	
87	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1		1		1		1		1	
88	tubing, pressure injection line (angiography)	SD211	item			1		1		1		1	
89	kit, AccuStick II Introducer System with RO Marker	SA071	kit	1		1		1		1		1	
90	vascular sheath	SD136	item	1		1		1		1		1	
91	guidewire, (Bentson)	SD172	item	1		1		1		1		1	
92	guidewire, hydrophilic (Glidewire)	SD089	item	1		1		1		1		1	

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				37224		36251		36252		36253		36254	
2	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation	CMS	Staff	Fem/Pop PTA Approved April 2010		Selective catheter placement (first-order); unilateral		Selective catheter placement (first-order); bilateral		Superselective catheter placement; unilateral		Superselective catheter placement; bilateral	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
93	catheter, angiographic, pig-tail	SC008	item	1		1		1		1		1	
94	catheter (SIM2F1)	SD148	item	1		1		1		1		1	
95	kit, guidewire introducer (Micro-Stick)	SA016	kit			1		1		1		1	
96	catheter microcatheter selective	SD154	item							1		1	
97	guidewire, steerable (Transcend)	SD175	item							1		1	
98	suture device for vessel closure (Perclose A-T)	SD207	item	1		1		1		1		1	
99	x-ray ID card (flashcard)	SK093	item	1		1		1		1		1	
100	film, x-ray 14inx17in	SK034	item	2		2		2		2		2	
101	x-ray envelope	SK091	item	1		1		1		1		1	
102	x-ray developer solution	SK089	oz	6		6		6		6		6	
103	x-ray fixer solution	SK092	oz	6		6		6		6		6	
104	heparin 1,000 units-ml inj	SH039	ml	5		5		5		5		5	
105	nitroglycerin injection USP 5 mg/mL (10ml uou vial)	SH096	item	1		1		1		1		1	
106	Sterile Radio-opaque ruler	SD249	item	1									
107	introducer sheath, Ansel (45 cm 6 Fr Ansel)	SD250	item	1									
108	guidewire, STIFF	SD090	item	1									
109	guidewire, Amplatz wire 260 cm	SD252	item	1									
110	catheter (Glide)	SD147	item	1									
111	Quick Cross Catheter	SC096	item	1									
112	catheter, balloon, low profile PTA	SD151	item	3									
113													
114	Equipment												
115	room, angiography	EL011		97		62		70		77		85	
116	IV infusion pump	EQ032		322		287		295		302		310	
117	Contrast medie warmer	EQ088		97		62		70		77		85	
118	film alternator	ER029		97		62		70		77		85	
119	ECG, 3-channel	EQ011		322		287		295		302		310	
120	Stretcher	EF018		322		0		0		0		0	
121	printer, dye sublimation	ED031		5		5		5		5		5	

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3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			000	000	000	000	000	000	000	000	000	000
5	TOTAL CLINICAL LABOR TIME			358	9	253	9	277	9	298	9	322	9
6		RN L051A	RN	142		107		115		122		130	
7		RN/LPN/MTA L037D	RN/LPN/MTA	50	9	41	9	43	9	45	9	47	9
8		Angio Tech L041A	AngioTech	91		59		67		74		82	
9		Angio Tech L041B	Rad Tech	75		46		52		57		63	
10	TOTAL PRE-SERV CLINICAL LABOR TIME			15	6	15	6	15	6	15	6	15	6
11	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			340	0	235	0	259	0	280	0	304	0
12	TOTAL POST-SERV CLINICAL LABOR TIME			3	3	3	3	3	3	3	3	3	3
13	PRE-SERVICE												
14	Start: Following visit when decision for surgery or procedure made												
15	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3
16	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		3		3		3		3	
17	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3		3		3
18	Provide pre-service education/obtain consent												
19	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3		3		3		3		3	
20	Other Clinical Activity (please specify): Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD	L041A	AngioTech	6		6		6		6		6	
21	End: When patient enters office/facility for surgery/procedure												
22	SERVICE PERIOD												
23	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure												
24	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	5		5		5		5		5	
25	Obtain vital signs	L037D	RN/LPN/MTA	5		5		5		5		5	
26	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5		5		5		5	
27	Prepare room, equipment, supplies (including imaging equipment)	L041B	Rad Tech	7		7		7		7		7	
28	Setup scope (non facility setting only)												
29	Prepare and position patient/ monitor patient/ set up IV	L041B	Rad Tech	5		5		5		5		5	
30	Sedate/apply anesthesia	L051A	RN	2		2		2		2		2	
31	Intra-service												
32	Assist physician in performing procedure	L041A	AngioTech	80		45		53		60		68	
33	Assist physician in performing procedure (CS)	L051A	RN	80		45		53		60		68	
34	Assisting with flouroscopy/image acquisition (75%)	L041B	Rad Tech	60		34		40		45		51	
35	Circulating throughout procedure (25%)	L037D	RN/LPN/MTA	20		11		13		15		17	
36	Image Post Processing	L041A	AngioTech	5		5		5		5		5	
37	Post-Service												
38	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60		60		60		60		60	
39	Clean room/equipment by physician staff	L041A	AngioTech	3		3		3		3		3	
40	Clean Scope												
41	Clean Surgical Instrument Package												
42	Complete diagnostic forms, lab & X-ray requisitions												

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3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
43	Review/read X-ray, lab, and pathology reports												
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3		3		3		3	
45	Discharge day management												
46	Other Clinical Activity (please specify)												
47	End: Patient leaves office												
48	POST-SERVICE Period												
49	Start: Patient leaves office/facility												
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3	3	3	3	3
51	Office visits: None												
59	Total Office Visit Time			0	0	0	0	0	0	0	0	0	0
60	Other Activity (please specify)												
61	End: with last office visit before end of global period				0		0		0		0		0
62	MEDICAL SUPPLIES		Unit										
63	pack, minimum multi-specialty visit	SA048	pack	1		1		1		1		1	
64	pack, conscious sedation	SA044	pack	1		1		1		1		1	
65	gown, surgical, sterile	SB028	item	2		2		2		2		2	
66	gloves, sterile	SB024	pair	2		2		2		2		2	
67	mask, surgical, with face shield	SB034	item	4		4		4		4		4	
68	cap, surgical	SB001	item	4		4		4		4		4	
69	shoe covers, surgical	SB039	pair	4		4		4		4		4	
70	tray, shave prep	SA067	tray	1		1		1		1		1	
71	underpad 2ftx3ft (Chux)	SB044	item	1		1		1		1		1	
72	drape, sterile, femoral	SB009	item	1		1		1		1		1	
73	drape-towel, sterile 18inx26in	SB019	item	4		4		4		4		4	
74	Betadine	SJ041	ml	60		60		60		60		60	
75	applicator, sponge-tipped	SG009	item	4		4		4		4		4	
76	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10		10		10		10		10	
77	syringe 10-12 ml	SC051	item	4		4		4		4		4	
78	syringe, 20 cc	SC053	item	4		4		4		4		4	
79	sodium chloride 0.9% flush syringe	SH065	item	2		2		2		2		2	
80	closed flush system, angiography	SC010	item	1		1		1		1		1	
81	blade, surgical (Bard-Parker)	SF007	item	1		1		1		1		1	
82	steri-strip (6 strip uou)	SG074	item	1		1		1		1		1	
83	guidewire bowl w-lid, sterile	SD171	item	2		2		2		2		2	
84	gauze, sterile 4in x 4in	SG056	item	2		2		2		2		2	
85	dressing 3 X 4 wound care telfa	SG035	item	2		2		2		2		2	
86	drape, sterile, c-arm, fluoro	SB008	item	1		1		1		1		1	
87	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1		1		1		1		1	
88	tubing, pressure injection line (angiography)	SD211	item			1		1		1		1	
89	kit, AccuStick II Introducer System with RO Marker	SA071	kit	1		1		1		1		1	
90	vascular sheath	SD136	item	1		1		1		1		1	
91	guidewire, (Bentson)	SD172	item	1		1		1		1		1	
92	guidewire, hydrophilic (Glidewire)	SD089	item	1		1		1		1		1	

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2	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation	CMS	Staff	Fem/Pop PTA Approved April 2010		Selective catheter placement (first-order); unilateral		Selective catheter placement (first-order); bilateral		Superselective catheter placement; unilateral		Superselective catheter placement; bilateral	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
93	catheter, angiographic, pig-tail	SC008	item	1		1		1		1		1	
94	catheter (SIM2F1)	SD148	item	1		1		1		1		1	
95	kit, guidewire introducer (Micro-Stick)	SA016	kit			1		1		1		1	
96	catheter microcatheter selective	SD154	item							1		1	
97	guidewire, steerable (Transcend)	SD175	item							1		1	
98	suture device for vessel closure (Perclose A-T)	SD207	item	1		1		1		1		1	
99	x-ray ID card (flashcard)	SK093	item	1		1		1		1		1	
100	film, x-ray 14inx17in	SK034	item	2		2		2		2		2	
101	x-ray envelope	SK091	item	1		1		1		1		1	
102	x-ray developer solution	SK089	oz	6		6		6		6		6	
103	x-ray fixer solution	SK092	oz	6		6		6		6		6	
104	heparin 1,000 units-ml inj	SH039	ml	5		5		5		5		5	
105	nitroglycerin injection USP 5 mg/mL (10ml uou vial)	SH096	item	1		1		1		1		1	
106	Sterile Radio-opaque ruler	SD249	item	1									
107	introducer sheath, Ansel (45 cm 6 Fr Ansel)	SD250	item	1									
108	guidewire, STIFF	SD090	item	1									
109	guidewire, Amplatz wire 260 cm	SD252	item	1									
110	catheter (Glide)	SD147	item	1									
111	Quick Cross Catheter	SC096	item	1									
112	catheter, balloon, low profile PTA	SD151	item	3									
113													
114	Equipment												
115	room, angiography	EL011		97		62		70		77		85	
116	IV infusion pump	EQ032		322		322		322		322		322	
117	Contrast medie warmer	EQ088		97		62		70		77		85	
118	film alternator	ER029		97		62		70		77		85	
119	ECG, 3-channel	EQ011		322		322		322		322		322	
120	Stretcher	EF018		322		322		322		322		322	
121	printer, dye sublimation	ED031		5		5		5		5		5	

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment – Codes Reported Together 75% or More Screen

April 2011

IVC Transcatheter Procedure

In February 2010, CPT code 37620 *Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)* was identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. This code has been billed commonly with 75940 and 36010. In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The Panel created four new codes for RUC review in April 2011.

36010 Introduction of catheter, superior or inferior vena cava

The RUC agreed with the specialties to delay review of this service until the September 2011 RUC meeting. The specialty societies explained that the top five diagnoses for this service are related to conditions that are now reported by the new IVC filter codes. Therefore, the utilization for 36010 is expected to drop significantly. In addition, the typical vignette and dominant provider may change. **The RUC recommends to delay the review of CPT code 36010 until the September 2011 RUC meeting.**

37191 Insertion of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

The RUC reviewed the survey results from 90 physicians for CPT code 37191. The RUC reviewed the survey's estimated work values and agreed with the specialties that the respondents overestimated the work value of this service. In order to accurately value this procedure, the RUC compared the surveyed code to an analogous percutaneous procedure CPT code 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (work RVU= 4.17) and agreed that these procedures are similar in both physician work and intra-service time, 30 minutes, respectively. However, 32550 does not include supervision and interpretation which is inherent in 37191. Adding the reported S&I code, 75940 *Percutaneous placement of IVC filter, radiological supervision and interpretation*, to the base code work value (4.17 + 0.54) equals a total value of 4.71. The RUC agreed that a work RVU of 4.71 is an accurate value for 37191. To further justify this value, the RUC compared 37191 to CPT code 52275 *Cystourethroscopy, with internal urethrotomy; male* (work RVU= 4.69) and agreed that the services have similar physician work with identical intra-service time of 30 minutes and should be valued similarly. **The RUC recommends a work RVU of 4.71 for CPT code 37191.**

37192 Repositioning of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

The RUC reviewed the survey results from 69 physicians for CPT code 37192. The RUC discussed and agreed with the specialties that the 75th percentile intra-service time of 60 minutes more accurately described the physician work involved in the service because removing a filter is more challenging than replacement because the filters are fixed to the wall and can be tilted. Also, the median survey service performance rate was 2 per year, suggesting that the survey respondents do not have great familiarity performing this service. The RUC reviewed the survey's estimated work values and agreed that the 25th percentile work RVU of 8.00 is an appropriate value for this service. To further justify this value, the RUC compared 37192 to the key reference service 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS)* (work RVU= 7.99) and agreed that while the reference code has greater intra-service time compared to 37192, 77.5 minutes compared to 60 minutes, the survey respondents consistently rated the surveyed code's physician work more intense in the intensity/complexity measures due to the risk of tearing the cava during the procedure. **The RUC recommends a work RVU of 8.00 for CPT code 37192.**

37193 Retrieval (removal) of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

The RUC reviewed the survey results from 74 physicians for CPT code 37193. The RUC discussed and agreed with the specialties that the 75th percentile intra-service time of 60 minutes more accurately described the physician work involved in the service because taking out a filter is more challenging than placing them because the filters are fixed to the wall and can be tilted. Also, the median survey service performance rate was 6 per year, suggesting that the survey respondents do not have great familiarity performing this service. The RUC reviewed the survey's estimated work values and agreed that the 25th percentile work RVU of 8.00 is an appropriate value for this service. To further justify this value, the RUC compared 37192 to the key reference service 37183 *Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS)* (work RVU= 7.99) and agreed while the reference code has greater intra-service time compared to 37193, 77.5 minutes compared to 60 minutes, the survey respondents consistently rated the surveyed code's physician work more intense in the intensity and complexity measures due to the risk of tearing the cava during the procedure. **The RUC recommends a work RVU of 8.00 for CPT code 37193.**

37619 Ligation of inferior vena cava

The RUC reviewed the survey results from 41 vascular and general surgeons and agreed with the specialties that the survey respondents underestimated the total physician work for this rarely performed service, by underestimating the significant post-operative work. The RUC concurred with the specialties that the 75th percentile work RVU of 37.60 is an accurate value for this intense procedure. To further justify this value, the RUC compared 37619 to the key reference service 35082 *Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta* (work RVU= 42.09) and agreed that these two services are analogous, intense procedures, requiring significant post-operative work, including ICU care. Bleeding from a ruptured major vein in the abdomen or pelvis is one of a surgeon's most difficult injuries to control. Ligation of the vena cava is only performed as a last effort to save a patient with massive venous bleeding, most often from trauma. Given these complexities, the key reference code is a suitable comparison, but with greater intra-service time compared to 37619, 180 minutes and 150 minutes, respectively. **The RUC recommends a work RVU of 37.60 for CPT code 37619.**

Work Neutrality

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

Practice Expense

The RUC reviewed the direct practice expense inputs recommended and made a few minor changes to them to reflect the typical patient service.

New Technology

The RUC requested that CPT codes 37192 and 37193 be placed on the new technology list to review the volume of this service in three years to ensure that the utilization assumptions were accurate.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
36010	X1	Introduction of catheter, superior or inferior vena cava	XXX	RUC Requests Postponement Until Sept 2011 RUC Meeting
◎●37191	W1	Insertion of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy) (For open surgical interruption of the inferior vena cava through a laparotomy or retroperitoneal exposure, use 37619)	000	4.71
◎●37192	W2	Repositioning of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy) (Do not report 37192 in conjunction with 37191)	000	8.00

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
◎●37193	W3	Retrieval (removal) of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy) (Do not report 37193 in conjunction with 37203, 75961)	000	8.00
●37619	X2	Ligation of inferior vena cava (For endovascular delivery of an inferior vena cava filter, use 37191)	090	37.60
E 37203		Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter) (For radiological supervision and interpretation, use 75961) (For removal of a vena cava filter, use 37193)	000	5.02 (No Change)
Ligation				
D 37620		Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device) (For radiological supervision and interpretation, use 75940) (37620 has been deleted. To report, see 37191 for endovascular placement of intravascular filter or 37619 for open surgical ligation of the inferior vena cava)	090	N/A
Radiology Diagnostic Radiology (Diagnostic Imaging) Transcatheter Procedures				

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
D 75940		Percutaneous placement of IVC filter, radiological supervision and interpretation (75940 has been deleted. To report, use 37191)	XXX	N/A
E 75961		Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation (For procedure, use 37203) (For removal of a vena cava filter, use 37193)	XXX	4.24 (No Change)
E +76937		Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure) (Do not report 76937 in conjunction with <u>37191, 37192, 37193, 37760, 37761, or 76942</u>)	ZZZ	0.30 (No Change)

April 5, 2011

Barbara Levy, MD
Chair, AMA/Specialty Society Relative Value Update Committee
515 N. State Street
Chicago, IL 60654

Re: CPT Code 36010

Dear Dr. Levy:

The undersigned societies would like to provide you with an update on CPT code 36010 *Introduction of catheter, superior or inferior vena cava*. This code was first identified on the 75% or more billed together screen (reported with 37620, 75825 and 75940). This combination of codes describes placement of IVC filter with 36010 reported to describe the catheter placement in the IVC. CPT code 36010 will be bundled into the three new IVC filter codes to be presented at the April RUC meeting.

We understand that the RUC is anticipating a presentation for CPT code 36010 at the upcoming RUC meeting. However, the multispecialty group (SIR, ACR, SVS, ACC and SCAI) respectfully requests a delay for surveying this code until a year of Medicare utilization data is collected.

Three of the top five diagnoses in the database for 36010 are DVT / PE related and will be captured by the new IVC filter codes. Therefore, the utilization for 36010 will drop significantly once the new IVC filter codes enter the CPT book next year. In addition, the typical vignette and dominant provider may change.

If the RUC decides against a delay until future Medicare utilization data can be collected, we are willing to present survey data to the RUC in October of 2011. If you have any questions, please don't hesitate to contact Trisha Crishock at SIR. She can be reached at trishac@tcpconsulting.net or (703)934-8272.

Sincerely,

Handwritten signature of Sean M. Tutton, MD in black ink.

Sean Tutton, MD
SIR RUC Advisor
Society of Interventional Radiology

Handwritten signature of Geraldine McGinty in black ink.

Geraldine McGinty, MD
ACR RUC Advisor
American College of Radiology

Handwritten signature of Gary R. Seabrook in black ink.

Gary Seabrook, MD
SVS RUC Advisor
Society of Vascular Surgery

cc: Sherry Smith, AMA
Roseanne Fischhoff, AMA
Susan Clark, AMA
Trisha Crishock, SIR, SVS
Dawn Hopkins, SCAI
Angela Kim, ACR
Brian Whitman, ACC

STAFF NOTE

IVC Transcatheter Procedures

During the RUC's deliberations for CPT code 37192 and 37193, it was noted that the specialties recommended the 75% percentile intra-service time of 60 minutes for these services as the survey respondents underestimated the time it takes to perform this procedure compared to the insertion code 37191. The specialty noted that to substantiate this view, Radiologists, the dominant provider of this service, indicated a intra-service time of 55 minutes for both codes. However, the specialties misspoke and this is the case for 37192 but not 37193. The specialty societies maintain that the typical intra-service time to perform this procedure is 60 minutes and requests that given the confusion the intra-service times be maintained at the 75th percentile for both of these similar services. Below is the raw survey data.

		37192 Reposition			37193 Removal		
		Rad	Sur	Combined	Rad	Sur	Combined
Typical		93%	81%	93%	98%	90%	95%
N=		42	27	69	45	29	74
Nw/SPR>1		35	14	49	44	20	64
SPR		3	1	2	10	4	6
Pre	<i>Eval</i>	40	55	40	35	60	37.5
	<i>Pos</i>	10	5	10	10	5	10
	<i>SDW</i>	10	10	10	10	10	10
Intra Time	<i>25th</i>	40	30	40	30	30	30
	<i>Median</i>	55	45	45	45	45	45
	<i>75th</i>	68.75	60	60	60	60	60
Post		20	15	15	20	15	15
RVU		9.00	8.70	9.00	9.00	9.00	9.00

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

CPT Code:37191 Tracking Number W1 Original Specialty Recommended RVU: **4.71**
Presented Recommended RVU: **4.71**
Global Period: 000 RUC Recommended RVU: **4.71**

CPT Descriptor: Insertion of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

(For open surgical interruption of the inferior vena cava through a laparotomy or retroperitoneal exposure, use 37619)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old woman has deep venous thrombosis of the leg and pulmonary embolus. Anticoagulation is contraindicated because of gastrointestinal bleeding. An inferior vena cava filter is placed.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 85%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings, underlying co-morbidities, and pre-procedural studies, the physician re-evaluates the clinical indications of the procedure and addresses the potential clinical variables involved in specific device selection. The range of specific catheters, sheaths, guidewires, and vena cava filters, is assessed and availability is ensured. Physician work also includes the following. Assess need for stand-by devices that might be needed depending on variant anatomy or suboptimal filter deployment (additional catheters, sheaths, guidewires, and snares). Review clinical and laboratory parameters with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Examine patient to assess for potential atypical venous anatomy secondary to acquired conditions related to acute or chronic thromboembolism or prior central venous catheters and update the H&P accordingly. Discuss procedure detail plan, including alternatives, risks, and overall filter treatment plan with patient and family. Obtain informed consent for procedure and conscious sedation. The appropriate vascular access is chosen and access site is marked. Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and that intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Ensure that ultrasound is available for the venous access specifically related to the surgical intervention.

Supervise sterile prep of access site, fluoroscopic imaging equipment, ultrasound imaging equipment, and surgical draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. A suitable access vein is cannulated using micropuncture technique and ultrasound guidance. A 5 French vascular sheath is placed. A standard access 0.035 wire and catheter are manipulated into the IVC with fluoroscopic guidance either via the femoral vein or in a trans-atrial fashion via the internal jugular vein. Breath-hold DSA imaging is obtained with calibrated pigtail catheter for sizing, documentation of anatomy, and assessment for central thromboembolism or stenosis. The position and number of renal veins is documented and marked to plan for optimal filter placement. A second stiff guidewire is advanced and the pigtail catheter is removed. Sequential dilation of the venotomy site is performed and using fluoroscopic guidance the filter delivery sheath is advanced. The filter is slowly deployed under fluoroscopic guidance subjacent to the lowest renal vein. Proper filter deployment is confirmed under magnified fluoroscopy and/or spot imaging in at least two projections. Final venography is performed to ensure proper alignment of the filter with the cava and appropriate position relative to the most inferior renal vein. The filter delivery sheath is removed and hemostasis is obtained with manual compression (with or without hemostasis assist device) or surgical closure of the venotomy.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). All appropriate medical records are completed, with copy to referring physician. Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, imaging, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, David Han, MD, Michael Sutherland, MD and Mathew Sideman, MD				
Specialty(s):	SIR, ACR and SVS				
CPT Code:	37191				
Sample Size:	2305	Resp N:	90	Response: 3.9 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	15.00	25.00	48.75
Survey RVW:		3.00	6.71	8.00	9.84
Pre-Service Evaluation Time:				30.00	
Pre-Service Positioning Time:				10.00	
Pre-Service Scrub, Dress, Wait Time:				10.00	
Intra-Service Time:		10.00	20.00	30.00	45.00
Immediate Post Service-Time:	15.00				
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
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:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	37191	Recommended Physician Work RVU: 4.71		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		30.00	33.00	-3.00
Pre-Service Positioning Time:		3.00	1.00	2.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		30.00		
Immediate Post Service-Time:	15.00			
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37221	000	10.00	RUC Time

CPT Descriptor Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
34812	000	6.74	RUC Time	33,522

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32550	000	4.17	RUC Time

CPT Descriptor Insertion of indwelling tunneled pleural catheter with cuff

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 18.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 37191	<u>Key Reference CPT Code:</u> 37221	<u>Source of Time</u> RUC Time
Median Pre-Service Time	38.00	48.00	
Median Intra-Service Time	30.00	90.00	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	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		
Median Total Time	83.00	168.00	

Other time if appropriate		
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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	3.88	3.69
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.75
--	------	------

Urgency of medical decision making	3.69	3.44
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.76	3.76
--------------------------	------	------

Physical effort required	3.29	3.18
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.41	3.53
---	------	------

Outcome depends on the skill and judgment of physician	3.94	3.88
--	------	------

Estimated risk of malpractice suit with poor outcome	3.82	3.82
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.29	3.18
----------------------------------	------	------

Intra-Service intensity/complexity	3.65	3.65
------------------------------------	------	------

Post-Service intensity/complexity	2.71	2.94
-----------------------------------	------	------

Additional Rationale and Comments

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

The expert panel reviewed the survey and recommendations of the survey participants. The survey itself was robust, consisting of 90 respondents from Interventional Radiology, Radiology and Vascular Surgery.

The panel was faced with an unusual situation in that there was a marked discrepancy between the surveyed median intraprocedural time (30 minutes) and the median recommended work value of 8.00 (IWPUT of 0.221). Even the 25th percentile RVW of 6.71 produced an inappropriately elevated IWPUT of 0.182.

Faced with the extremely rare situation of persistent marked discordance between work estimates (in which the survey participants use classic magnitude estimation) and time measures, the panel struggled to arrive at a fair value for what is a well understood and widely performed endovascular procedure which like many other endovascular procedures involves catheterization of a large vessel, diagnostic angiography and deployment of an intravascular device.

It was the opinion of the expert panel that the intra-time estimate (30 min) was accurate. The reference services 37221 and 36478 were analogous endovascular therapeutic procedures well understood by the respondents, yet classic magnitude of total work estimates produced IWPUTs that were far too high even at the 25th percentile (0.182).

Therefore, the panel examined the most likely work-equivalent procedures in the universe of RUC-surveyed procedural codes with 000 day globals and 30 minutes of intra time. In general these codes ranged in value from 2.00 to 5.34 with invasive percutaneous procedures with more attendant risk, stress and effort clustered in the 3.30 (33210 temporary transvenous pacing) to 4.79 (93454 Coronary artery catheterization) range. The panel felt that an analogous percutaneous procedure was 32550 *Insertion of indwelling tunneled pleural catheter with cuff* (RVW 4.17). Additionally, since IVC filter placement involves considerable imaging, the current S&I code for IVC 75940 (RVW: 0.54) would also be included yielding a total value of 4.71 (4.17+0.54) with an IWPUT of 0.116.

The panel felt that compared to pleural catheter placement, deployment of an IVC filter involved more risk, mental stress and effort (bleeding, catheterization of the right heart, performance and interpretation of a diagnostic vascular study and precise deployment of an intravascular device which can migrate and perforate) than pleural catheter drainage, but less risk and effort than coronary or cardiac catheterization.

Work RVU Recommendation

We are recommending an RVW of 4.71. This value is cross walked to the sum of work RVUs for 32550 plus 75940. This value also falls appropriately between the total work for codes 33210 and 93454.

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.

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

CPT Code:37192 Tracking Number W2

Original Specialty Recommended RVU: **8.00**Presented Recommended RVU: **8.00**

Global Period: 000

RUC Recommended RVU: **8.00**

CPT Descriptor: Repositioning of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

(Do not report 37192 in conjunction with 37191)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old woman with pulmonary embolus had placement of a temporary IVC filter. Follow-up CT scan has identified migration and angulation of the IVC filter. The patient has an on-going contraindication to anticoagulation (gastrointestinal bleeding). Filter re-positioning is performed.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 90%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings, underlying co-morbidities, and pre-procedural studies, the physician re-evaluates the clinical indications of the procedure and addresses the potential clinical variables involved in specific retrieval device and replacement filter selection. The range of specific catheters, sheaths, guidewires, and vena cava filters is assessed and availability is ensured. Physician work also includes the following. Assess need for stand-by devices or additional vascular access that might be needed depending on specific position of the existing filter and length of time the filter has been in place (additional catheters, sheaths, guidewires, balloons, snares, and blunt dissection tools). Ensure availability of suitable replacement filter. Review clinical and laboratory parameters with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Examine patient to assess for extremity, facial, or truncal changes that may signify interval acquired conditions related to acute or acute on chronic thromboembolism or interval central venous catheters and update the H&P accordingly. The appropriate vascular access is chosen. Discuss procedure detail plan, including alternatives, risks, and overall filter treatment plan with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access site(s). Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices.

Ensure the patient is appropriately positioned on the table and that intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Ensure that ultrasound is available for the venous access specifically related to the surgical intervention. Supervise sterile prep of access site, fluoroscopic imaging equipment, ultrasound imaging equipment, and surgical draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. A suitable access vein is cannulated using micropuncture technique and ultrasound guidance. A 5 French vascular sheath is placed. A standard access 0.035 wire and catheter are manipulated into the IVC with fluoroscopic guidance typically in a trans-atrial fashion via the internal jugular vein. Initial fluoroscopy and or spot imaging is obtained to assess for position of the existing filter. Breath-hold DSA imaging is obtained in at least two obliquities with calibrated pigtail catheter for sizing, documentation of anatomy, and assessment for central thromboembolism or stenosis. Based on preliminary venography the existing filter is extensively evaluated for trapped thromboembolism, fibrin sheath, and filter cone positioning relative to the caval wall. Presence or absence of filter fixation leg penetration is inspected and additionally imaging is obtained as necessary to satisfactorily inspect these variables. A stiff 0.035 guidewire is advanced and the pigtail catheter is removed. Sequential dilation of the venotomy site is performed and using fluoroscopic guidance the telescoping filter retrieval sheaths are advanced adjacent to the filter. The snare device is advanced and initial attempts are made to snare the filter cone. Once the filter cone is grasped with either the initial snare device, subsequent snare device, or blunt dissection tool, attempts are made to slowly collapse the filter into the telescoping sheath system while paying close fluoroscopic and clinical attention to limit the potential for caval laceration. Once the filter is collapsed the filter is repositioned under fluoroscopic guidance to a more suitable location based on anatomic landmarks and venocavagram. The filter is then re-deployed in an appropriate position based on prior and intra-procedural imaging. Proper filter deployment is confirmed under magnified fluoroscopy and/or spot imaging in at least two projections. Final venography is performed to ensure proper alignment of the filter with the cava and appropriate position relative to the renal veins. The filter delivery sheath is removed and hemostasis is obtained with manual compression (with or without hemostasis assist device) or surgical closure of the venotomy.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). All appropriate medical records are completed, with copy to referring physician. Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, imaging, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, David Han, MD, Michael Sutherland, MD and Mathew Sideman, MD				
Specialty(s):	SIR, ACR and SVS				
CPT Code:	37192				
Sample Size:	2305	Resp N:	69	Response: 2.9 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	0.00	2.00	5.00
Survey RVW:		2.91	8.00	9.00	15.00
Pre-Service Evaluation Time:				40.00	
Pre-Service Positioning Time:				10.00	
Pre-Service Scrub, Dress, Wait Time:				10.00	
Intra-Service Time:		5.00	40.00	45.00	60.00
Immediate Post Service-Time:	15.00				
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:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	37192	Recommended Physician Work RVU: 8.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		3.00	1.00	2.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	15.00			
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37183	000	7.99	RUC Time

CPT Descriptor Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		
<u>CPT Descriptor 1</u>				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		
<u>CPT Descriptor 2</u>				

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	
<u>CPT Descriptor</u>			

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

Compare the pre-, intra-, and post-service time (by the median) and the 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:** 24.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 37192	<u>Key Reference CPT Code:</u> 37183	<u>Source of Time</u> RUC Time
Median Pre-Service Time	41.00	27.50	
Median Intra-Service Time	60.00	77.50	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	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	116.00	135.00
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	3.65	3.35
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.53
Urgency of medical decision making	3.29	3.18

Technical Skill/Physical Effort (Mean)

Technical skill required	4.24	3.88
Physical effort required	3.53	3.47

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.94	3.59
Outcome depends on the skill and judgment of physician	4.18	3.88
Estimated risk of malpractice suit with poor outcome	4.06	3.59

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.53	3.53
Intra-Service intensity/complexity	3.88	3.59
Post-Service intensity/complexity	2.88	3.06

Additional Rationale and Comments

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

The expert panel reviewed the survey and recommendations of the survey participants. The survey itself was robust, consisting of 69 respondents from both Interventional Radiology and Vascular Surgery.

As in 37191 the panel was again faced with a situation in that there was a discrepancy between the surveyed median intraprocedural time (45 minutes) and the median recommended work value of 9.00 (IWPUT of 0.166). The 25th percentile RVW of 8.00 gave a relatively high IWPUT of 0.150.

It was the opinion of the panel that time estimates were not accurate; the median number of procedures performed in the past year was only 2, thus the panel believes that many respondents have no real ability to accurately estimate the time of such an infrequently performed service. The reference service 37183 (RVW: 7.99 IWPUT 0.086) is analogous in terms of overall work but has 78 minutes of intraservice time.

Additionally, regarding time estimates, the panel noted that interventional radiologists had considerably more experience and expertise with this procedure; their time estimates were a median of 55 minutes. Thus, the panel believes that median time estimates are inaccurate and chose to take the 75th percentile of time (60 minutes) as it reflected the greater expertise of the more experienced participants.

The panel felt that compared to TIPS revision, the multiple elements of IVC filter revision involved similar risk, mental stress and effort (bleeding, catheterization of the right heart, performance and interpretation of a diagnostic vascular study and precise snaring and redeployment of an intravascular device which can migrate and perforate).

Given the fact that the panel believed that time estimates are less accurate in this survey and based on similarity to the reference service, we selected the 25th percentile or 8.00 and recommend a time of 60 minutes, yielding an IWPUT of 0.114.

Work RVU Recommendation

We are recommending an RVW of 8.00 and a time of 60 minutes.

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) Unlisted 37799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)

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

CPT Code:37193 Tracking Number W3

Original Specialty Recommended RVU: **8.00**Presented Recommended RVU: **8.00**

Global Period: 000

RUC Recommended RVU: **8.00**

CPT Descriptor: Retrieval (removal) of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

(Do not report 37193 in conjunction with 37203, 75961)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old male had placement of an inferior vena cava filter for deep venous thrombosis and gastrointestinal bleeding. The filter is no longer needed and is retrieved using an endovascular approach.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? Yes

Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 88%

Is moderate sedation inherent to this procedure in the office setting? Yes

Percent of survey respondents who stated moderate sedation is typical in the office setting? 0%

Is moderate sedation inherent in your reference code (Office setting)? Yes

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? Yes

Description of Pre-Service Work: Based on patient symptoms, signs, physical findings, underlying co-morbidities, and pre-procedural studies, the physician re-evaluates the clinical indications of the procedure and addresses the potential clinical variables involved in specific retrieval device selection. The appropriate vascular access is chosen. The range of specific catheters, sheaths, and guidewires is assessed and availability is ensured. Physician work also includes the following. Assess need for stand-by devices or additional vascular access that might be needed depending on specific position of the existing filter and length of time the filter has been in place (additional catheters, sheaths, guidewires, balloons, snares, and blunt dissection tools). Review clinical and laboratory parameters with special attention to anticoagulant or antiplatelet therapy, contrast allergy, electrolytes, BUN, creatinine, and CBC to assure patient suitability for planned procedure. Examine patient to assess for extremity, facial, or truncal changes that may signify interval acquired conditions related to acute or acute on chronic thromboembolism or interval central venous catheters and update the H&P accordingly. Discuss procedure detail plan, including alternatives, risks, and overall filter treatment plan with patient and family. Obtain informed consent for procedure and conscious sedation. Mark access site(s). Check interventional suite to ensure proper function and configuration of imaging equipment including compliance with radiation safety issues. Ensure all technical personnel have been familiarized with the upcoming procedure and techniques and that they are fully familiar with all required devices. Ensure the patient is appropriately positioned on the table and that intravenous access has been achieved. Don radiation protection gear and ensure that all who will be in the interventional suite do likewise. Ensure that

ultrasound is available for the venous access specifically related to the surgical intervention. Supervise sterile prep of access site, fluoroscopic imaging equipment, ultrasound imaging equipment, and surgical draping. Perform pre-procedural "time-out."

Description of Intra-Service Work: Conscious sedation is administered and adequate conscious sedation monitoring is verified. A suitable access vein is cannulated using micropuncture technique and ultrasound guidance. A 0.018 wire is advanced centrally and the access needle is removed. The micropuncture dilator is placed and the 0.018 guidewire is exchanged for a standard access 0.035 wire. The micropuncture dilator is removed and a 5 French vascular sheath is placed. The 0.035 wire and 4 or 5 French catheter are manipulated into the IVC with fluoroscopic guidance typically in a trans-atrial fashion via the internal jugular vein. Initial fluoroscopy and or spot imaging is obtained to assess for position of the existing filter. Breath-hold DSA imaging is obtained in at least two obliquities with calibrated pigtail catheter for sizing, documentation of anatomy, and assessment for central thromboembolism or stenosis. Based on preliminary venography the existing filter is extensively evaluated for trapped thromboembolism, fibrin sheath, and filter cone positioning relative to the caval wall. Presence or absence of filter fixation leg penetration is determined and additional imaging is obtained as necessary to satisfactorily inspect these variables. A stiff 0.035 guidewire is advanced and the pigtail catheter is removed. Sequential dilation of the venotomy site is performed and using fluoroscopic guidance, the telescoping filter retrieval sheaths are advanced adjacent to the filter. The snare device is advanced and initial attempts are made to snare the filter cone. Once the filter cone is grasped with either the initial snare device, subsequent snare device, or blunt dissection tool, attempts are made to slowly collapse the filter into the telescoping sheath system while paying close fluoroscopic and clinical attention to limit the potential for caval laceration. Once the filter is collapsed the filter is removed under fluoroscopic guidance along with the inner telescoping sheath. The filter is inspected and venography is repeated to ensure caval integrity and to assess for residual clot and or fibrin sheath at the filter site. The filter delivery sheath is removed and hemostasis is obtained with manual compression (with or without hemostasis assist device) or surgical closure of the venotomy.

Description of Post-Service Work: Apply sterile dressings. As needed, assist team in moving patient to stretcher. Discuss post-procedure care with recovery area staff. Write post-procedure orders for care and pain medication. Write brief procedure note. Record contrast volume and radiation exposure time. Review all films and dictate interpretation. Repeat patient exam and assessment of vital signs multiple times in recovery area, as needed. Monitor groin puncture site for hematoma. Discuss findings and treatment with family and patient (when awake). All appropriate medical records are completed, with copy to referring physician. Depending on the preexisting comorbidities and operative course, the patient may require full hospital admission, overnight hospital stay, or same day discharge. The patient is transferred to the appropriate care setting when recovery area discharge criteria are met, with appropriate orders for follow-up labs, imaging, and patient care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Sean Tutton, MD, Robert Vogelzang, MD, Jerry Niedzwiecki, MD, Michael Hall, MD, Zeke Silva, MD, Gary Seabrook, MD, Robert Zwolak, MD, David Han, MD, Michael Sutherland, MD and Mathew Sideman, MD				
Specialty(s):	SIR, ACR and SVS				
CPT Code:	37193				
Sample Size:	2305	Resp N:	74	Response: 3.2 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	3.00	6.00	15.75
Survey RVW:		4.00	8.00	9.00	10.50
Pre-Service Evaluation Time:				40.00	
Pre-Service Positioning Time:				10.00	
Pre-Service Scrub, Dress, Wait Time:				10.00	
Intra-Service Time:		15.00	30.00	45.00	60.00
Immediate Post Service-Time:	15.00				
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
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:

2b -FAC Diff Pat/Straightfor Proc(w sedation/anes)

CPT Code:	37193	Recommended Physician Work RVU: 8.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		3.00	1.00	2.00
Pre-Service Scrub, Dress, Wait Time:		5.00	5.00	0.00
Intra-Service Time:		60.00		
Immediate Post Service-Time:	15.00			
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37183	000	7.99	RUC Time

CPT Descriptor Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 17 **% of respondents:** 22.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 37193	<u>Key Reference CPT Code:</u> 37183	<u>Source of Time</u> RUC Time
Median Pre-Service Time	41.00	27.50	
Median Intra-Service Time	60.00	77.50	
Median Immediate Post-service Time	15.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	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	116.00	135.00
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	3.35	3.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.35	3.53
Urgency of medical decision making	2.71	3.12

Technical Skill/Physical Effort (Mean)

Technical skill required	4.24	3.76
Physical effort required	3.65	3.47

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.76	3.65
Outcome depends on the skill and judgment of physician	4.29	4.00
Estimated risk of malpractice suit with poor outcome	4.29	3.47

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.12	3.24
Intra-Service intensity/complexity	3.53	3.47
Post-Service intensity/complexity	2.82	3.00

Additional Rationale and Comments

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

The expert panel reviewed the survey and recommendations of the survey participants. The survey itself was large, consisting of 74 respondents from both Interventional Radiology and Vascular Surgery.

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? 6,394

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is currently reported by both CPT code 37203 (Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)) and its associated radiology supervision and interpretation CPT code 75961 or by the unlisted code 37799. 85% of the time 37203 is billed with 75961 (3094). It is estimated that the majority of the unlisted code 37799 is currently billed for this service (3300). 3094 + 3300= 6,394.

Specialty Radiology Frequency 4156 Percentage 64.99 %

Specialty Vascular Surgery Frequency 1279 Percentage 20.00 %

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

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. 37620

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

CPT Code:37619 Tracking Number X1 Original Specialty Recommended RVU: **37.60**
Presented Recommended RVU: **37.60**
Global Period: 090 RUC Recommended RVU: **37.60**

CPT Descriptor: Ligation of inferior vena cava
(For endovascular delivery of an inferior vena cava filter, use 37191)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old male sustains penetrating trauma to the flank. He is emergently taken for exploratory laparotomy and a retroperitoneal hematoma is identified. Exploration reveals a complex injury to the inferior vena cava below the level of the renal veins. His tenuous condition requires that the inferior vena cava be ligated.

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 100% , 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% , Kept overnight (less than 24 hours) 0% , Admitted (more than 24 hours) 100%

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 78%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Work begins after the decision to operate and includes review of the procedural work-up and all associated E/M services (eg emergency physician findings etc), review of pre-operative studies, JCAHO-mandated H&P update, final discussion with patient and family, final informed consent discussion, review patient comorbidities with anesthesia, don OR scrubs, ensure all necessary equipment is present, position the patient, scrub, gown, prep and drape. Perform time-out to verify correct patient and procedure.

Description of Intra-Service Work: Rapidly perform laparotomy incision & explore abdomen to identify site of hemorrhage. Assess location and status of renal vein and hepatic veins as well as adjacent organs including liver, spleen, and bowel mesentery. Communicate with anesthesiologist as to overall status of the patient, collaborating regarding fluid and transfusion therapy to ensure adequate volume replacement. Rapidly configure ring forceps with sponges to occlude the flow of blood through the inferior vena cava to stop bleeding, and manually compress vena cava and or clamp aorta if patient has exsanguinating hemorrhage, avoiding injury to adjacent viscera. Perform Kocher maneuver to expose the vena cava by rotating the colon, duodenum, and pancreas medially. Rapidly dissect soft tissue from surface of bleeding inferior vena cava taking care to avoid injury to the right renal vessels. Use digital pressure to control hemorrhage, employing vascular clamps as required. Assess the injury to the vena cava to determine if any form of repair can be performed. Since repair is always preferred over ligation, the typical patient will undergo significant efforts at repair prior to decision to ligate (and in this situation there would be no way to report the failed work of attempted repair). Once determined that the vena cava is not able to be repaired, rapidly expose the vessel ends sufficiently to allow ligation. Suture ligate the superior

and inferior ends of the IVC. Apply additional sutures as needed to control hemorrhage. Listen with Doppler to the renal vessels to assure adequate flow pattern and determine there is no injury to the renal artery or vein during the ligation. Correct coagulopathy with fresh frozen plasma, platelets, and cryoprecipitate. Re-explore abdomen to ensure there are no other injuries. Irrigate wound to wash out hematoma. Confirm final sponge and instrument count. Check again for hemostasis and close laparotomy fascia. Evaluate lower legs for impaired venous return and the potential need for prophylactic lower extremity four compartment fasciotomies.

Description of Post-Service Work: Apply sterile dressings. Help transfer patient from OR table to gurney. Assist transport to Post-anesthesia Care Unit (PACU) or Intensive Care Unit (ICU). Stabilize patient upon arrival. Write post-op orders and notes. Dictate operative note. Communicate with PACU/ICU nurses and referring physicians. Discuss case with family. Discuss case with patient following emergence from anesthesia. Perform multiple post-operative checks on day of surgery with particular attention to compromised venous return in lower extremities due to IVC ligation. Direct daily attention to surgical wounds, limb edema, nutrition, renal function. Write daily orders and progress notes. Prepare patient for discharge, including communication with PCP, referring MD, rehab providers, physical therapists, home care nursing. Dictate discharge summary. Perform outpatient visits as required for 90 days.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	Gary Seabrook, MD, Robert Zwolak, MD, David Han, MD, Michael Sutherland, MD and Mathew Sideman, MD, Christopher Senkowski, MD and Charles Mabry, MD					
Specialty(s):	vascular surgery, general surgery					
CPT Code:	37619					
Sample Size:	393	Resp N:	41	Response: 10.4 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	0.00	1.00	8.00
Survey RVW:		20.00	25.00	30.00	37.60	49.02
Pre-Service Evaluation Time:				55.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				15.00		
Intra-Service Time:		60.00	120.00	150.00	180.00	240.00
Immediate Post Service-Time:	60.00					
Post Operative Visits	Total Min**	CPT Code and Number of Visits				
Critical Care time/visit(s):	140.00	99291x 2.00	99292x 0.00			
Other Hospital time/visit(s):	175.00	99231x 2.00	99232x 2.00	99233x 1.00		
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00	99217x 0.00		
Office time/visit(s):	62.00	99211x 0.00	12x 1.00	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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	37619	Recommended Physician Work RVU: 37.60		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		40.00	40.00	0.00
Pre-Service Positioning Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress, Wait Time:		15.00	20.00	-5.00
Intra-Service Time:		150.00		
Immediate Post Service-Time:	60.00			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	140.00	99291x 2.00	99292x 0.00	
Other Hospital time/visit(s):	175.00	99231x 2.00	99232x 2.00	99233x 1.00
Discharge Day Mgmt:	38.00	99238x 1.0	99239x 0.0	99217x 0.00
Office time/visit(s):	62.00	99211x 0.00	12x 1.00	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
35082	090	42.09	RUC Time

CPT Descriptor Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
<u>CPT Descriptor 1</u>		0.00		
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
<u>CPT Descriptor 2</u>		0.00		

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
37617	090	23.79	RUC Time

CPT Descriptor Ligation, major artery (eg, post-traumatic, rupture); abdomen

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 13 % of respondents: 31.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 37619	<u>Key Reference CPT Code:</u> 35082	<u>Source of Time</u> RUC Time
Median Pre-Service Time	58.00	60.00	
Median Intra-Service Time	150.00	180.00	
Median Immediate Post-service Time	60.00	60.00	
Median Critical Care Time	140.0	140.00	
Median Other Hospital Visit Time	175.0	273.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	62.0	79.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	683.00	792.00	
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	3.92	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	3.31
--	------	------

Urgency of medical decision making	4.85	4.85
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.77	4.77
--------------------------	------	------

Physical effort required	4.92	4.92
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.77	4.85
---	------	------

Outcome depends on the skill and judgment of physician	4.77	4.77
--	------	------

Estimated risk of malpractice suit with poor outcome	4.31	4.31
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	4.38	4.54
----------------------------------	------	------

Intra-Service intensity/complexity	4.77	4.85
------------------------------------	------	------

Post-Service intensity/complexity	4.38	4.46
-----------------------------------	------	------

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWP/UT 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?

CPT Code 37620 (Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device), was identified by the 2010 Five Year Workgroup in a screen for codes reported together 75% or more, and in April 2010 the Workgroup accepted a multispecialty society recommendation to refer this code to CPT to better define the service.

A vena cava filter, placed with a percutaneous catheter technique, is uniformly the procedure of choice to protect the patient from pulmonary embolism by preventing blood clots from traversing through the vena cava. Open surgical ligation, clipping, or plication is an antiquated technique for prevention of PE. Direct surgery treatment of the vena cava now is indicated for traumatic injuries, making the vignette for 37619 appropriate.

At the February 2011 CPT Panel, it was decided that existing code 37620 should be deleted with creation of two new codes, one to represent the vastly more common procedure of percutaneous IVC filter placement, and a second to represent the very uncommon procedure of open ligation of the IVC. The new code, 37619, represents the latter of these two services, open surgical ligation, which would typically be performed only as a last ditch attempt to control life-threatening hemorrhage.

Reporting frequency for 37619 will be extremely low. In fact, we predict less than 100 reports of open IVC ligation 37619 per year, compared to thousands of the percutaneous vena cava filter placement. Budget neutrality will not be an issue because the sum of work RVUs for the new percutaneous filter placement code plus this new code will be substantially less than the current total.

Pre-time

Pre-time package 4 (facility- difficult patient/difficult procedure) is appropriate. Scrub, Dress, and Wait time is 15 minutes per survey vs. 20 minutes per package due to urgency of procedure.

Comparison to key reference code

The key reference code 35082 (Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta) was RUC valued at the 2010 Five Year Review, and describes work to repair a disrupted a major abdominal artery providing a similar clinical scenario to 37619 describing injury to major abdominal vein.

It may seem counter-intuitive that a traumatically ruptured vena cava could approach the intensity of a ruptured aortic aneurysm, but in fact this is true. As noted in more detail below, bleeding from a ruptured major vein in the abdomen or pelvis is one of the surgeon's most frustratingly difficult injuries to control. In fact, attempts at vascular control oftentimes result in even more injury to the cava than previously existed, and the surgical team oftentimes loses the battle when attempting to control massive venous bleeding. Thus, it is reasonable to compare this new venous ligation code to a ruptured abdominal aortic aneurysm code.

For RVW comparison, 35082 has an intratime of 180 minutes and a work RVU of 42.09. Compared to 35082 with an IWPUT of 0.098, there are 30 fewer minutes of intratime for 37619 ($30 \times 0.098 = 2.94$ RVUs). There are fewer postoperative visits (one less 99231 and one less 99232 for 37619 compared to reference 35082). This is a difference of $(0.76 + 1.39)$ 2.15 fewer RVUs for 37619. There are the same number of office visits for the two codes, with a slight variation in distribution. For 35082 office visits (99214, -13, -12) account for 2.95 RVUs compared to 2.48 RVUs for 37619 (99213, -13, -12). Given the similar clinical scenarios for these two codes, and adjusting for the differences in intra and post service time, the recommend 75% median survey value of 37.60 is justified when compared to the reference service code value of 42.09. $42.09 - (2.94 \text{ (intra time)}) + 2.15 \text{ (hospital visits)} + 0.53 \text{ (office visits)} = 36.47$

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post	Hosp	office
35802	42.09	0.098	792	60			180	60	99291, 91, 33, 32, 32, 32, 31, 31,31,38	99214, 13, 12
37619	37.60	0.108	683	40	3	15	150	60	99291, 91, 33, 32, 32, 31, 31, 38	99213, 13, 12

At our proposed RVW, the IWPUT for 37619 falls within the range of intensity for emergent vascular procedures in the abdomen. Our consensus panel concluded that an injury requiring ligation of the vena cava created a higher level of intra-operative intensity than that associated with a ruptured aortic aneurysm making the higher IWPUT (0.108 vs. 0.098) appropriate. The thin walled structure of the vena cava confounds easy clamping of the vessel and requires sutures to be very delicately placed to prevent tearing while the ligation procedure is being performed.

Comparison to other CPT code

Code 37619 could also be compared to 37617 (Ligation, major artery (eg, post-traumatic, rupture); abdomen) which was RUC valued at the 2nd Five Year Review, and also describes work to repair an abdominal blood vessel. 37617 has an

intratime of 120 minutes and a work RVU of 23.79. The IWPUT of 0.104 is similar to the IWPUT of 0.108 for 37619. The 30 minute difference in intratime with an IWPUT of 0.104 equates to 3.12 fewer RVUs for 37617 compared to 37619. There are two fewer postoperative visits (99291 x 2) for 37617. This is a difference of (4.50 x 2) 9.00 fewer RVUs than for 37619. Code 37619 has 15 more minutes of immediate post service time (15 x 0.022) compared to 37617 adding 0.33 RVUs. There is one less office visit for the two codes with a slight variation in distribution. For 37617 office visits (99213, -12) account for 1.45 RVUs compared to 2.48 RVUs for 37619 (99213, -13, -12). When relative work for 37619 is compared to 37617 RVW of 23.70 + 3.12 (intra time) + 9.00 (hospital visits) + 0.33 (immediate post service time) + 1.45 (office visits) = 37.27, the recommend 75% median survey value of 37.60 is justified.

	RVW	IWPUT	Total Time	Eval	Posit	SDW	INTRA	IM-post	hosp	office
37617	23.79	0.104	475	58			120	45	99233, 32, 32, 31, 31, 38	99213, 12
37619	37.60	0.108	683	40	3	15	150	60	99291, 91, 33, 32, 32, 31, 31, 38	99213, 13, 12

PLI:

Key reference service is an appropriate crosswalk.

Compelling Evidence:

We do not believe this code requires a compelling evidence discussion because it is a new distinct procedure, substantially dissimilar to the intent of parent code 37620. In addition, we do not believe there is a budget neutrality issue because the work recommendation for 372X1 is substantially less than the current value, and the ratio of claims for the percutaneous filter code 37191 to the IVC ligation code 37619 will be at least 1000:1

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) 37620 and 75940

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 Vascular Surgery

How often? Rarely

Specialty General Surgery How often? Rarely

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. We are not able to estimate how often this service will be provided nationally in a one-year period.

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? 65 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is a rarely performed procedure. We assume that 0.1% of the currently reported CPT code 37620 would be treated with open surgical ligation.

Specialty Vascular Surgery Frequency 35 Percentage 53.84 %

Specialty General Surgery Frequency 30 Percentage 46.15 %

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

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. 35082

AMA/Specialty Society RVS Update Committee Recommendation

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

CPT Long Descriptors:

37191 Insertion of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

(For open surgical interruption of the inferior vena cava through a laparotomy or retroperitoneal exposure, use 37619)

37192 Repositioning of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

(Do not report 37192 in conjunction with 37191)

37193 Retrieval (removal) of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

(Do not report 37193 in conjunction with 37203, 75961)

Global Periods: 000

Meeting Date: April 2011

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

The multispecialty organizations (SIR, ACR and SVS) convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for these newly created CPT codes.

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

We selected CPT code 37221 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* as our comparison code. The procedures, processes and resources are comparable. CPT code 37221 was recently RUC'ed/PEAC'ed (April 2010).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Phone calls & prescriptions
- Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD

Intra-Service Clinical Labor Activities:

The patient is greeted, gowning is provided and patient is escorted to procedure room. The nurse obtains vital signs, interviews the patient for allergies, medications and coagulopathy. Procedure is explained and informed consent is witnessed. The rad tech prepares the room, equipment and supplies after consulting with the M.D regarding the supplies to be used. The angio tech prepares the back table. IV access is established. The patient is positioned, skin is prepped and the patient is draped. RN administers conscious sedation. The angio tech assists the M.D. performing procedure. The rad tech assists the MD with flouro, contrast, image acquisition, etc. The patient is escorted to the observation area. RN performs sequential vital signs over 4 hour observation. RT processes the images and completes all the necessary paperwork. The angio tech cleans the room. The patient is given discharge instructions.

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

CPT Code: 37191-93

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

CPT Long Descriptors:

37191 Insertion of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

(For open surgical interruption of the inferior vena cava through a laparotomy or retroperitoneal exposure, use 37619)

37192 Repositioning of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

(Do not report 37192 in conjunction with 37191)

37193 Retrieval (removal) of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)

(Do not report 37193 in conjunction with 37203, 75961)

Global Periods: 000

Meeting Date: April 2011

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

The multispecialty organizations (SIR, ACR, SVS, ACC and SCAI) convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for these newly created CPT codes.

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

We selected CPT code 37221 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* as our comparison code. The procedures, processes and resources are comparable. CPT code 37221 was recently RUC'ed/PEAC'ed (April 2010).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Schedule space and equipment in facility

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

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

CPT Long Descriptor:

Ligation of inferior vena cava

(For endovascular delivery of an inferior vena cava filter, use 37191)

Global Period: 090

Meeting Date: April 2011

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

A standard RUC survey was conducted for physician work. An expert panel reviewed the recommendations for physician work and makes the following practice expense recommendations.

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

No comparison code was used for these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No clinical time is recommended for this code, due to the emergent nature of this procedure.

Intra-Service Clinical Labor Activities:

The standard time for discharge day management has been recommended for this procedure.

Post-Service Clinical Labor Activities:

Standard times to ready patient/records and assist physician at each post-op office visit have been applied.

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I
1				37191		37192		37193	
2	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation								
		CMS	Staff	<i>Insertion of intravascular vena cava filter</i>		<i>Repositioning of intravascular vena cava filter</i>		<i>Retrieval of intravascular vena cava filter</i>	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			000	000	000	000	000	000
5	TOTAL CLINICAL LABOR TIME			208	9	298	9	298	9
6		RN L051A	RN	92		122		122	
7		RN/LPN/MTA L037D	RN/LPN/MTA	38	9	45	9	45	9
8		Angio Tech L041A	AngioTech	44		74		74	
9		Angio Tech L041B	Rad Tech	35		57		57	
10	TOTAL PRE-SERV CLINICAL LABOR TIME			15	6	15	6	15	6
11	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			190		280		280	
12	TOTAL POST-SERV CLINICAL LABOR TIME			3	3	3	3	3	3
13	PRE-SERVICE								
14	Start: Following visit when decision for surgery or procedure made								
15	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	3	3	3	3	3	3
16	Coordinate pre-surgery services	L037D	RN/LPN/MTA	3		3		3	
17	Schedule space and equipment in facility	L037D	RN/LPN/MTA		3		3		3
18	Provide pre-service education/obtain consent								
19	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	3		3		3	
20	Other Clinical Activity (please specify): Retrieve prior imaging exams, hang for MD review, verify orders, review chart to incorporate relevant clinical information, confirm contrast protocol with interpreting MD	L041A	AngioTech	6		6		6	
21	End: When patient enters office/facility for surgery/procedure								
22	SERVICE PERIOD								
23	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure								
24	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	5		5		5	
25	Obtain vital signs	L037D	RN/LPN/MTA	5		5		5	
26	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	5		5		5	
27	Prepare room, equipment, supplies (including imaging equipment)	L041B	Rad Tech	7		7		7	
28	Setup scope (non facility setting only)								
29	Prepare and position patient/ monitor patient/ set up IV	L041B	Rad Tech	5		5		5	
30	Sedate/apply anesthesia	L051A	RN	2		2		2	
31	Intra-service								
32	Assist physician in performing procedure	L041A	AngioTech	30		60		60	
33	Assist physician in performing procedure (CS)	L051A	RN	30		60		60	
34	Assisting with flouroscopy/image acquisition (75%)	L041B	Rad Tech	23		45		45	
35	Circulating throughout procedure (25%)	L037D	RN/LPN/MTA	8		15		15	
36	Image Post Processing	L041A	AngioTech	5		5		5	
37	Post-Service								
38	Monitor pt. following service/check tubes, monitors, drains	L051A	RN	60		60		60	
39	Clean room/equipment by physician staff	L041A	AngioTech	3		3		3	
40	Clean Scope								
41	Clean Surgical Instrument Package								
42	Complete diagnostic forms, lab & X-ray requisitions								
43	Review/read X-ray, lab, and pathology reports								
44	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L037D	RN/LPN/MTA	3		3		3	
45	Discharge day management								
46	Other Clinical Activity (please specify)								
47	End: Patient leaves office								

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I
1				37191		37192		37193	
2	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation								
		CMS	Staff	<i>Insertion of intravascular vena cava filter</i>		<i>Repositioning of intravascular vena cava filter</i>		<i>Retrieval of intravascular vena cava filter</i>	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
48	POST-SERVICE Period								
49	Start: Patient leaves office/facility								
50	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA	3	3	3	3	3	3
51	Office visits: None								
59	Total Office Visit Time			0	0	0	0	0	0
60	Other Activity (please specify)								
61	End: with last office visit before end of global period								
62	MEDICAL SUPPLIES		Unit						
63	pack, minimum multi-specialty visit	SA048	pack	1		1		1	
64	pack, conscious sedation	SA044	pack	1		1		1	
65	gown, surgical, sterile	SB028	item	2		2		2	
66	gloves, sterile	SB024	pair	2		2		2	
67	mask, surgical, with face shield	SB034	item	4		4		4	
68	cap, surgical	SB001	item	4		4		4	
69	shoe covers, surgical	SB039	pair	4		4		4	
70	tray, shave prep	SA067	tray	1		1		1	
71	underpad 2ftx3ft (Chux)	SB044	item	1		1		1	
72	drape, sterile, femoral	SB009	item	1		1		1	
73	drape-towel, sterile 18inx26in	SB019	item	4		4		4	
74	Betadine	SJ041	ml	60		60		60	
75	applicator, sponge-tipped	SG009	item	4		4		4	
76	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	10		10		10	
77	syringe 10-12 ml	SC051	item	4		4		4	
78	syringe, 20 cc	SC053	item	4		4		4	
79	sodium chloride 0.9% flush syringe	SH065	item	2		2		2	
80	closed flush system, angiography	SC010	item	1		1		1	
81	blade, surgical (Bard-Parker)	SF007	item	1		1		1	
82	steri-strip (6 strip uou)	SG074	item	1		1		1	
83	guidewire bowl w-lid, sterile	SD171	item	2		2		2	
84	gauze, sterile 4in x 4in	SG056	item	2		2		2	
85	dressing 3 X 4 wound care telfa	SG035	item	2		2		2	
86	drape, sterile, c-arm, fluoro	SB008	item	1		1		1	
87	disinfectant, surface (Envirocide, Sanizide)	SM013	oz	1		1		1	
88	cover-condom, transducer or ultrasound probe	SB005	item	1		1		1	
89	sheath-cover, sterile, 96in x 6in (transducer)	SB048	item	1		1		1	
90	tubing, pressure injection line (angiography)	SD211	item	1		1		1	
91	Sterile Radio-opaque ruler (le Maitre, documentation available)	SD249	item	1		1		1	
92	kit, guidewire introducer (Micro-Stick)	SA016	kit	1		1		1	
93	guidewire, (Bentson)	SD172	item	1		1		1	
94	catheter, angiographic, pig-tail	SC008	item	1		1		1	
95	vascular sheath	SD136	item	1		1		1	
96	introducer sheath, Ansel [45 cm 6 Fr Ansel	SD250	item			1		1	
97	Vena Cava Filter (documentation attached)	NEW	item	1					
98	Filter Retrieval Set (documentation attached)	NEW	kit			1		1	
99	Hemostatic Patch	NEW	item	1		1		1	
100	x-ray ID card (flashcard)	SK093	item	1		1		1	
101	film, x-ray 14inx17in	SK034	item	2		2		2	
102	x-ray envelope	SK091	item	1		1		1	
103	x-ray developer solution	SK089	oz	6		6		6	
104	x-ray fixer solution	SK092	oz	6		6		6	
105	heparin 1,000 units-ml inj	SH039	ml						
106	protamine sulfate 10 mg/ml (5ml uou vial)	SH095	item						
107	nitroglycerin injection USP 5 mg/mL (10ml uou vial)	SH096	item						
108	kit, AccuStick II Introducer System with RO Marker	SA071	kit						
109	catheter, (SIM2F1)	SD148	item						

AMA Specialty Society Recommendation

	A	B	C	D	E	F	G	H	I
1				37191		37192		37193	
2	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation	CMS	Staff	Insertion of intravascular vena cava filter		Repositioning of intravascular vena cava filter		Retrieval of intravascular vena cava filter	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
110	suture device for vessel closure (Perclose A-T)	SD207	item						
111	guidewire, STIFF	SD090	item						
112	guidewire, hydrophilic (Glidewire)	SD089	item						
113	catheter (Glide)	SD147	item						
114	Quick Cross Catheter (Sprectranetics, documentation available)	SC096	item						
115	catheter, balloon, low profile PTA	SD151	item						
116	stent, vascular, deployment system, Cordis SMART [6-12/14 mm]	SA103	kit						
117									
118	Equipment								
119	room, angiography	EL011		47		77		77	
120	IV infusion pump	EQ032		332		332		332	
121	Contrast medie warmer	EQ088		47		62		62	
122	film alternator	ER029		47		62		62	
123	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		332		332		332	
124	Stretcher	EF018		332		332		332	
125	printer, dye sublimation	ED031		5		5		5	
126	ultrasound unit, portable	EQ250		47		62		62	

AMA Specialty Society Recommendation

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			37619	
2	Meeting Date: April 2011 Specialty: Vascular Surgery & General Surgery	CMS	Staff	<i>Ligation of inferior vena cava</i>	
3	LOCATION	Code	Type	Non Facility	Facility
4	GLOBAL PERIOD			90	90
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	111.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	12.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	99.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms				0
12	Coordinate pre-surgery services				0
13	Schedule space and equipment in facility				0
14	Provide pre-service education/obtain consent				0
15	Follow-up phone calls & prescriptions				0
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/MTA		12
39	End: Patient leaves office/facility				
40	POST-SERVICE Period				
41	Start: Patient leaves office/facility				
44	<i>List Number and Level of Office Visits</i>				
45	99211 16 minutes		16		
46	99212 27 minutes		27		1
47	99213 36 minutes		36		2
48	99214 53 minutes		53		
49	99215 63 minutes		63		
50	<i>Total Office Visit Time</i>				99
52	End: with last office visit before end of global period				
53	MEDICAL SUPPLIES				
54	pack, minimum multi-sof-setspecialty visit	SA048	pack		3
55	kit, staple removal	SA030	kit		1
56	Equipment				
57	table, power	EF031			99
58	light, surgical	EQ168			99

AMA/Specialty Society RVS Update Committee
Summary of Recommendations

February 2011

Bone Marrow Stem Cell Revisions

In October 2010, the CPT Editorial Panel split CPT code 38230 into two separate codes: 38232 *Bone marrow harvesting for transplantation; autologous* and 38230 *Bone marrow harvesting for transplantation; allogeneic*. When code 38232 was developed, and RUC reviewed in 1995, allogeneic transplants were performed the large majority of the time. Currently, the majority of transplants performed are allogeneic using bone marrow/stem cells from a related or unrelated donor. Additionally, CMS approved a change in the global period from 010 to 000, which was requested due to the fact that very few of these harvests require overnight hospitalization and physician follow-up in the days following the procedure.

38230 *Bone marrow harvesting for transplantation; allogeneic*

The RUC reviewed and agreed with the specialty survey results from 57 hematologists for CPT code 38230. The RUC agreed with the addition of 12 minutes of pre-service positioning time to account for turning the patient over from supine to the prone position, while under general anesthesia. These additional minutes of positioning time are a RUC standard for complicated patients under general anesthesia in spine procedure. The RUC recommends pre-service time of 55 minutes, intra-service time of 90 minutes and post service time of 30 minutes. The RUC analyzed the survey's estimated physician work and agreed that the data supports the median work RVU of 4.00. To further justify this recommended value, the RUC compared the surveyed code to key reference CPT code 38205 *Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic* (work RVU= 1.50 and intra-time= 45 minutes). The RUC agreed that while there is similar physician work involved in code 38230 and the reference code, the surveyed code should be valued greater due to longer required intra-service time, 90 minutes and 45 minutes, respectively.

The RUC also compared the surveyed code to reference code 38242 *Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions* (work RVU= 1.71 and intra-time= 30 minutes). Again, the RUC noted that while these services have similar physician work the surveyed code is the most intense procedure many of these physician do and should be valued higher due to longer required intra-service time, 90 minutes and 30 minutes, respectively. Finally, the RUC discussed the difference in work RVUs between 38232 and 38230. Even though the intra-service time between the two services are similar, the intra-service work for 38230 is more intense and stressful because it is necessary to manage the donor while performing a procedure that is not for the donor's benefit. The need to obtain more cells because of the risk of graft rejection, graft versus host disease and ABO mismatching as well as the need to accommodate cell loss at the time of removal and when the cells are processed increases the stress and intensity of the procedure. This was substantiated by the survey respondents who stated that 38230 has a higher intensity and complexity in physician work in 8 of the measures compared to 38232. **The RUC recommends a work RVU of 4.00 for CPT code 38230.**

38232 Bone marrow harvesting for transplantation; autologous

The RUC reviewed and agreed with the specialty survey results from 57 hematologists for CPT code 38232. The RUC agreed with the addition of 12 minutes of pre-service positioning time to account for turning the patient over from supine to the prone position, while under general anesthesia. These additional minutes of positioning time are a RUC standard for complicated patients under general anesthesia for spine procedures. The RUC recommends pre-service time of 45 minutes, intra-service time of 90 minutes and post service time of 30 minutes. The RUC analyzed the survey's estimated physician work and agreed that the data supports the median estimated work RVU of 3.50. To further justify this recommended value, the RUC compared the surveyed code to key reference CPT code 38206 *Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous* (work RVU= 1.50 and intra-time= 35 minutes). The RUC agreed that the surveyed code should be valued greater than the reference code given the large difference in physician intra-time required to perform these procedures, 90 minutes and 35 minutes, respectively. Additionally, survey respondents rated code 38232 higher in every intensity and complexity measure compared to code 38206.

The RUC also compared the surveyed service to reference code 38242 *Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions* (work RVU= 1.71 and intra-time= 30 minutes). The specialties noted that code 38232 is a very intense service in the family of codes and should be valued greater than this reference service due to greater total time, 90 minutes and 30 minutes, respectively. Finally, to ensure that the recommended work RVU of 3.50 is appropriate for this service, the RUC noted that the current work value of 38232 is 4.85 which is for a 010 global period and includes one 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.97). Subtracting the value of the post-operative visit (0.97 work RVUs) leaves 3.88 work RVUs. Given these references, the RUC agreed that the recommended median work value of 3.50 appropriately accounts for the physician work involved in this service. **The RUC recommends a work RVU of 3.50 for CPT code 38232.**

Work Neutrality

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

Practice Expense:

The RUC agreed that there were no direct inputs in the facility nor the non-facility settings as recommended by the specialty.

CPT Editorial Panel:

The RUC had a extensive discussion regarding the appropriate Evaluation and Management billing for CPT code 38240 *Bone marrow or blood-derived peripheral stem cell transplantation; per allogenic donor*. The RUC expressed concern that implementing CCI edits to preclude reporting an Evaluation and Management service on the same date of service would limit the ability for physicians to report the separately identifiable visit prior to the procedure on the same date. Given this, the RUC, and the specialty agreed, that this service should be referred back to the CPT Editorial Panel along with the family of services, CPT codes 38241 and 38242, to examine the current descriptors and descriptions of physician work to ensure these services are currently reported correctly and can be properly valued by the RUC. The specialty also mentioned that there is currently no common understanding of what services are reflected in the work of this service. CPT coding clarification and a RUC re-survey will provide for consistent reporting and appropriate valuation.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲38208	F1	Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, <u>per donor</u> (For diagnostic thawing and expansion of frozen cells, see 88241)	XXX	Postponement until after CPT Editorial Panel Review of 38240
▲38209	F2	thawing of previously frozen harvest, with washing, <u>per donor</u>	XXX	Postponement until after CPT Editorial Panel Review of 38240
▲38230	F4	Bone marrow harvesting for transplantation; <u>allogeneic</u> (For autologous and allogenic blood-derived peripheral stem cell harvesting for transplantation, see 38205-38206)	010 000	4.00
●38232	F3	autologous	000	3.50
▲38240	F5	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic <u>allogeneic</u>	XXX	Refer to CPT Editorial Panel



Physician Payment Policy and Systems

American Medical Association
515 North State Street
Chicago, Illinois 60654
Sherry L. Smith, Director

January 10, 2011

Dear Director Smith –

During the October CPT Editorial Board Meeting, the American Society for Blood and Marrow Transplantation (ASBMT) submitted change applications for four codes:

- 38208 – Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing.
- 38209 - Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing.
- 38230 – Bone marrow harvesting for transplantation
- 38240 – Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic

Since the Editorial Board meeting, the ASBMT has engaged in conversations with CMS staff that have resulted in a decision to delay the surveys of two of these codes – 38208 and 38209 – for the time being. We anticipate additional discussions with CMS in the next few weeks and the potential need for additional edits to the codes. We will communicate this information as soon as it becomes available.

Sincerely,

A handwritten signature in dark ink, appearing to read "J. Gajewski".

Dr. James Gajewski
Chair, Reimbursement Committee
American Society of Blood and Marrow Transplantation (ASBMT)

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

CPT Code:38232 Tracking Number F3 Original Specialty Recommended RVU: **3.5**
 Presented Recommended RVU: **3.5**
 Global Period: 000 RUC Recommended RVU: **3.5**

CPT Descriptor: Bone marrow harvesting for transplantation, autologous

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Patient is a 66-year-old man with multiple myeloma who is unable to have a peripheral blood stem cell collection because of the use of pre-transplant Revlimid. The patient's marrow cellularity is approximately 20%.

Percentage of Survey Respondents who found Vignette to be Typical: 54%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 43%

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? 21%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Update history and physical to assure patient can undergo procedure. Obtain informed consent. Explain procedure to patient and family. Change into scrubs. Consult with anesthesiologist as needed.

Description of Intra-Service Work: The patient is brought to the operating room and general anesthesia is administered. Approximately 400 needle sticks are administered to collect bone marrow from the posterior iliac crest. Blood is given to the patient for red blood cell support as needed. The patient is moved to the supine position, is extubated and transferred to the recovery room.

Description of Post-Service Work: Post-operative assessment and monitoring of the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011				
Presenter(s):	James Gajewski, MD; Samuel Silver, MD				
Specialty(s):	American Society for Blood and Marrow Transplantation (ASBMT); American Society of Hematology (ASH)				
CPT Code:	38232				
Sample Size:	1220	Resp N:	57	Response: 4.6 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	0.00	2.00	5.00
Survey RVW:		0.97	2.25	3.50	5.00
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				15.00	
Intra-Service Time:		5.00	60.00	90.00	120.00
Immediate Post Service-Time:	30.00				
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		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 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); 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:	38232	Recommended Physician Work RVU: 3.50		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		15.00	33.00	-18.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:	30.00			
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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
38206	000	1.50	RUC Time

CPT Descriptor Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99291	XXX	4.50	RUC Time	4,161,789

CPT Descriptor 1 Critical care, evaluation or management; first 30-74 minutes

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	5,805,837

CPT Descriptor 2 Initial hospital care, per day; 70 minutes at bedside or on patient's hospital floor

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
38241	XXX	2.24	RUC Time

CPT Descriptor Bone marrow or blood-derived peripheral stem cell transplantation, autologous**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 19 % of respondents: 33.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 38232	<u>Key Reference CPT Code:</u> 38206	<u>Source of Time</u> RUC Time
Median Pre-Service Time	45.00	40.00	
Median Intra-Service Time	90.00	35.00	
Median Immediate Post-service Time	30.00	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	165.00	95.00	
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	3.47	3.26
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.95	3.63
--	------	------

Urgency of medical decision making	3.79	3.47
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.74
--------------------------	------	------

Physical effort required	4.00	3.74
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.58	3.37
---	------	------

Outcome depends on the skill and judgment of physician	3.95	3.63
--	------	------

Estimated risk of malpractice suit with poor outcome	3.63	3.21
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.47	3.21
----------------------------------	------	------

Intra-Service intensity/complexity	3.95	3.53
------------------------------------	------	------

Post-Service intensity/complexity	3.21	3.00
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Additional Rationale and Comments

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

Background

At the October 2010 CPT Editorial Board meeting, CPT code 38230 (*Bone marrow harvesting for transplantation*) was split into separate codes:

- 38232: Bone marrow harvesting for transplantation; autologous

- 38230: Bone marrow harvesting for transplantation; allogeneic

When Code 38230 was developed and last reviewed (1995), the volume of allogeneic transplants was very low because most transplants were autologous; a split into autologous and allogeneic harvesting was not warranted at that time. This has changed dramatically. Currently, the majority of transplants performed are allogeneic using bone marrow/stem cells from a related or unrelated donor. This prompted the coding request to the CPT Editorial Board which resulted in a split of the current code into two.

Autologous and allogeneic bone marrow harvests differ in both patient population and physician work. The existence of two CPT codes to describe these procedures will facilitate appropriate coding and payment.

This code is now limited to autologous transplants and the vignette has been updated. The former vignette from 1995 was an uncomplicated patient receiving an autologous transplant for treatment of breast cancer. The procedure is no longer performed for this use and the current typical patients are more complicated clinically and more heavily pre-treated with chemotherapy (e.g., patients with leukemia or multiple myeloma).

Survey Notes:

- 1. Typical Vignette:** 54.39% of survey respondents answered affirmatively that the presented vignette for 38232 was typical of their patients. Those who indicated that this was not a typical patient were primarily pediatricians and noted their typical patient is a small child.
- 2. Global Period:** CMS approved a change in the global period from 010 to 000, which was requested due to the fact that very few of these harvests require overnight hospitalization and physician follow-up in the days following the procedure.
- 3. Service Performance Rate:** Of the 57 respondents, 19 reported that they had not performed this service personally within the last calendar year. This is not surprising, nor does it affect the results of the survey. The primary reason for this is that harvesting adult bone marrow for use in transplantation is performed only when the collection of peripheral blood stem cells fails or if marrow is specifically requested due to the type of disease or age of the recipient. Approximately ten years ago, the majority of transplants were performed with cells harvested from bone marrow specimens so practically all of the respondents have performed numerous harvests in the past, but it is not surprising that some of them would not have had the need to harvest cells in this manner within the last year. This does not mean they are unfamiliar with the procedure.
- 4. Survey Reference Codes:** The reference code list for this survey was limited. Transplant physicians typically specialize in Internal Medicine or Hematology/Oncology and do not perform surgical procedures outside of harvesting bone marrow or placing central lines. As we were instructed to only include codes with which the specialty members would be familiar, this greatly limited the number of similar surgical codes that could be included as points of comparison. This is also why a number of codes were included that have not previously been RUC surveyed. There are a very limited number of procedure codes performed by this specialty group and eliminating the non-RUC surveyed codes would have left only the standard office visit, inpatient care and critical care codes. The Research Committee approved the use of these codes due to the limitations of the situation.
- 5. Frequency Reporting**
The RUC database shows that orthopedic surgeons and neurosurgeons frequently utilized code 38232. This is an incorrect use of the code, which was clarified in a CPT Assistant article in June 2009. We expect the future reporting of this code to reflect the specialties of other transplant codes – Hem/Onc, Internal Medicine and Medical Oncology.

Recommendations:

We are recommending the survey median work value, the median intra and post times and are recommending a reduction in the pre-time as described below. The median RVW is 3.5 with the 25th percentile and the 75th percentile being 2.25 and 5.0 respectively. These times result in an IWPUT for 38232 of 0.023 which is extremely low for a surgical procedure requiring anesthesia.

The recommended value is supported by comparison to the key reference service and to several MPC codes. The key reference service, Code 38206 (describing blood derived stem cell harvesting) is assigned an RVW of 1.50 based on intra time of 35 minutes (1/2 that of the surveyed procedure), and pre-time of 40 minutes and post-time for 20

minutes. The intensity and complexity measures for the intra service portion of the procedure were higher for the surveyed code as were the specific measures for technical skill, physical effort, risk of malpractice and outcome being dependent on the skill and judgment of the physician. As noted earlier there were very few reference codes available for this survey and no other operating room codes that could be usefully compared to the procedure. Comparison to 38206, which was reviewed by the RUC in September 2002, strongly supports an RVU of 3.5 for 38230 because 38232 has an intra-time that is almost 3X longer (90 vs. 35 min), is much more intense and requires much more technical skill. In addition, the post service time is longer than that of 38206 (30 vs. 20 minutes) and is more intense because the patient was under anesthesia and is recovering from a surgical procedure.

CPT code 38242, Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions, which was reviewed by the RUC in April 2002 also supports the median RVU for 38232. 38242 has a work RVU of 1.71 and pre, intra and post times of 30, 30, and 20 minutes respectively.

We also note that current work RVU of 38230 is 4.85 which is for a 10 day global and include a post operative visit valued at 99213 or 0.97 work RVUs. Subtracting 0.97 from 4.85 leaves 3.88. Note that same day post op work for 38232 is still included in the code.

Therefore, the median of 3.5 is well supported by services within the same family.

We would like to specifically discuss the basis for the requested increment between 38232 and 38230 which is 0.5 works RVU. Even though the intraservice times for 38232 and 38230 in the surveys were similar, the intra-service work of 38230 is more intense and stressful because it is necessary to manage the donor while performing a procedure that is NOT for the donor's benefit. In fact, while performing the procedure and collecting marrow, it is the recipient's needs that must be kept in mind. The need to obtain more cells because of the risk of graft rejection, graft vs. host disease and ABO mismatching as well as the need to accommodate cell loss at the time of removal and when the cells are processed increases the stress and intensity of the procedure. Additionally, we believe that the respondents may have underestimated the intra-service time for 38230 because allogeneic donors are either unrelated donors, mismatched related donors, or matched sibling donors which, as described above, mean a much higher cell dose from the donor is required, thus requiring longer operative time for harvesting than with an autologous harvest. Therefore, we are unclear as to why the survey times came out similarly.

With respect to services outside of this family, we reviewed the following codes which support our request:
000 Globals - all have been reviewed by the RUC.

- 36556, Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older. This 000 global code has a work RVU of 2.5 with pre, intra and post times of 25, 15 and 10 minutes respectively. This is an MPC code.
- 32603, Thoracoscopy, diagnostic (separate procedure); pericardial sac, without biopsy. This 000 global code has a work RVU of 7.8 with pre, intra and post times of 83, 90 and 120 minutes respectively. This is an MPC code.
- 43240, Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst. This 000 global code has a work RVU of 6.85 and pre, intra and post times of 20, 90 and 20 minutes respectively. This is an MPC code.
- 45380, Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple. This code has a work RVU of 4.43 and pre, intra and post times of 45, 51.5 and 22 minutes respectively. This code is an MPC code.
- 31638, Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required). This code has a work RVU of 4.88 and pre, intra and post times of 50, 60 and 30 minutes respectively.
- 52001, Cystourethroscopy with irrigation and evacuation of multiple obstructing clots. This code has a work RVU of 5.44 and pre, intra and post times of 50, 60 and 20 minutes respectively.

XXX Globals - all have been reviewed by the RUC.

- 99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; a comprehensive examination; Medical decision making of

high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family. This XXX global code has a work RVU of 3.17 and pre, intra and post times of 7, 45 and 15 minutes respectively. This is an MPC code.

- 99223, Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit. This XXX global code has a work RVU of 3.86 and pre, intra and post times of 15, 55 and 20 minutes respectively. This code has an IWPUT of 0.05559 which is about two and one half times the requested IWPUT for 38230. This is an MPC code.
- 99327, Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver. This XXX global code has a work RVU of 3.46 and pre, intra and post times of 15, 60 and 25 minutes respectively
- 95978, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour. This XXX global code has a work RVU of 3.5 and pre, intra and post times of 5, 60 and 5 minutes respectively.
- 91110, Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with physician interpretation and report. This code has a work RVU of 3.64 and pre, intra and post times of 5, 80 and 15 minutes respectively.
- 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes. This code has a work RVU of 4.5 and pre, intra and post times of 15, 40 and 15 minutes respectively. Note that this code has an IWPUT of 0.0957 which is about four times the recommended IWPUT for 38230.

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) 38230

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 Hematology/Oncology How often? Sometimes

Specialty Medical Oncology How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1200

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. There are an estimated 12,000 autologous transplants per year in the United States and an estimated 10% of these utilize bone marrow as the cell source.

Specialty Hematology/Oncology Frequency 800 Percentage 66.66 %

Specialty Medical Oncology Frequency 200 Percentage 16.66 %

Specialty Internal Medicine Frequency 200 Percentage 16.66 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 225

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated split between 28230 and 3823X1

Specialty Hematology/Oncology Frequency 150 Percentage 66.66 %

Specialty Medical Oncology Frequency 38 Percentage 16.88 %

Specialty Internal Medicine Frequency 37 Percentage 16.44 %

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 38230

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:38230 Tracking Number F4 Original Specialty Recommended RVU: **4.0**
Presented Recommended RVU: **4.0**
Global Period: 000 RUC Recommended RVU: **4.0**

CPT Descriptor: Bone marrow harvesting for transplantation, allogeneic

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Patient is a 65-year-old woman with aplastic anemia who has failed antithymocyte immunoglobulin therapy with cyclosporine. The patient has a sibling donor who is fully HLA matched.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 38%

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? 17%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Update history and physical to assure donor can undergo procedure. Obtain informed consent. Explain procedure to donor and family. Change into scrubs. Consult with anesthesiologist as needed.

Description of Intra-Service Work: The donor is brought to the operating room and general anesthesia is administered. Approximately 400 needle sticks are administered to collect bone marrow from the posterior iliac crest. Blood is given to the donor for red blood cell support and as needed irradiated packed RBCs are provided. The donor is moved to the supine position, is extubated and transferred to the recovery room.

Description of Post-Service Work: Post-operative assessment and monitoring of the donor.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011			
Presenter(s):	James Gajewski, MD; Samuel Silver, MD				
Specialty(s):	American Society for Blood and Marrow Transplantation (ASBMT); American Society of Hematology (ASH)				
CPT Code:	38230				
Sample Size:	1224	Resp N:	47	Response: 3.8 %	
Sample Type:	Convenience Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	2.00	3.00	9.00
Survey RVW:		1.50	3.09	4.00	14.00
Pre-Service Evaluation Time:				20.00	
Pre-Service Positioning Time:				15.00	
Pre-Service Scrub, Dress, Wait Time:				20.00	
Intra-Service Time:		40.00	60.00	90.00	120.00
Immediate Post Service-Time:		30.00			
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		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 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); 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:	38230	Recommended Physician Work RVU: 4.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		20.00	33.00	-13.00
Pre-Service Positioning Time:		15.00	3.00	12.00
Pre-Service Scrub, Dress, Wait Time:		20.00	15.00	5.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:		30.00		
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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
38205	000	1.50	RUC Time

CPT Descriptor Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99291	XXX	4.50	RUC Time	4,161,789

CPT Descriptor 1 Critical care, evaluation or management; first 30-74 minutes

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	5,805,837

CPT Descriptor 2 Initial hospital care, per day; 70 minutes at bedside or on patient's hospital floor

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
38241	XXX	2.24	RUC Time

CPT Descriptor Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 31.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 38230	<u>Key Reference CPT Code:</u> 38205	<u>Source of Time</u> RUC Time
Median Pre-Service Time	55.00	38.00	
Median Intra-Service Time	90.00	45.00	
Median Immediate Post-service Time	30.00	30.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	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	175.00	113.00	
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	3.60	3.67
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	4.00
--	------	------

Urgency of medical decision making	3.93	3.93
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.13	4.07
--------------------------	------	------

Physical effort required	4.33	3.80
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.80	3.80
---	------	------

Outcome depends on the skill and judgment of physician	4.07	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	3.87	3.73
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.47	3.53
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Intra-Service intensity/complexity	3.73	3.67
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Post-Service intensity/complexity	3.40	3.33
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Additional Rationale and Comments

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

Background

At the October 2010 CPT Editorial Board meeting, CPT code 38230 (*Bone marrow harvesting for transplantation*) was split into separate codes:

- 38232: Bone marrow harvesting for transplantation; autologous

- 38230: Bone marrow harvesting for transplantation; allogeneic

When Code 38230 was developed and last reviewed (1995), the volume of allogeneic transplants was very low because most transplants were autologous; a split into autologous and allogeneic harvesting was not warranted at the time. This has changed dramatically. Currently, the majority of transplants performed are allogeneic using bone marrow/stem cells from a related or unrelated donor. This prompted the coding request to the CPT Editorial Board which resulted in a split of the current code into two. Autologous and allogeneic bone marrow harvests differ in both patient population and physician work. The existence of two CPT codes to describe these procedures will facilitate appropriate coding and payment.

Allogeneic donors are either unrelated donors, mismatched related donors, or matched sibling donors. If there is a significant HLA mismatch between donor and recipient, marrow harvest is preferred to peripheral harvest because of less recipient complications. In addition, marrow donation is often safer for the donor if he/she has major cardiovascular co-morbidities. However, a high cell dose from the donor is required, thus requiring longer operative time for harvesting than with an autologous harvest.

Survey Notes:

1. **Typical Vignette:** 76.6% of survey respondents answered affirmatively that the presented vignette for 38230 was typical of their patients. Those who indicated that this was not a typical patient were primarily pediatricians and noted their typical patient is a small child.
2. **Global Period:** CMS approved a 000 global period to mirror the change request submitted for 38232 from a 10 day to a 000 day global service. The change in the global period from 010 to 000 was requested due to the fact that very few of these harvests require overnight hospitalization and physician follow-up in the days following the procedure.
3. **Service Performance Rate:** Of the 47 respondents, 9 reported that they had not performed this service personally within the last calendar year. This is not surprising, nor does it affect the results of the survey. The primary reason for this is that harvesting adult bone marrow for use in transplantation is performed only when the collection of peripheral blood stem cells fails or if marrow is specifically requested due to the type of disease or age of the recipient. Approximately ten years ago, the majority of transplants were performed with cells harvested from bone marrow specimens so practically all of the respondents have performed numerous harvests in the past, but it is not surprising that some of them would not have had the need to harvest cells in this manner within the last year. This does not mean they are unfamiliar with the procedure.
4. **Survey Reference Codes:** The reference code list for this survey was limited. Transplant physicians typically specialize in Internal Medicine or Hematology/Oncology and do not perform surgical procedures outside of harvesting bone marrow or placing a central line. As we were instructed to only include codes with which the specialty members would be familiar, this greatly limited the number of similar surgical codes that could be included as points of comparison. This was why a number of codes were included that have not previously been RUC surveyed. There are a very limited number of procedure codes performed by this specialty group and eliminating the non-RUC surveyed codes would have left only the standard office visit, inpatient care and critical care codes. The Research Committee approved the use of these codes due to the limitations of the situation.
5. **Frequency Reporting**
The RUC database shows that orthopedic surgeons and neurosurgeons frequently utilized code 38230. This is an incorrect use of the code, which was clarified in a CPT Assistant article in June 2009. We expect the future reporting of this code to reflect the specialties of other transplant codes – Hem/Onc, Internal Medicine and Medical Oncology.

Recommendations:

We are recommending the work value and the intra and post times based on the median survey data and are recommending a reduction in pre-service time as discussed below. The median RVW is 4.0 with the 25th percentile and the 75th percentile being 3.09 and 5.0 respectively. The recommended times result in an IWPUT for 38230 of 0.028 which is extremely low for a surgical procedure requiring anesthesia.

The recommended value is supported by comparison to the key reference service and to several MPC codes. The key reference service, Code 38205 is assigned an RVW of 1.50 based on intra time of 45 minutes (1/2 that of the surveyed procedure) and pre and post times of 38 and 30 minutes respectively. The intensity and complexity measures for the procedure were higher for the surveyed code as were the specific measures for technical skill, physical effort, risk of malpractice and outcome being dependent on the skill and judgment of the physician. As noted earlier, there were very few reference codes available for this survey and no other operating room codes that could be usefully compared to the procedure.

Comparison to 38205, which was reviewed by the RUC in September 2002, strongly supports an RVU of 4.0 for 38230 because 38230 has an intra-time that is 2X longer (90 vs. 45 min), is much more intense and requires much more technical skill. In addition the post service time, while similar in length to 38205, is more intense because the patient was under anesthesia and is recovering from a surgical procedure.

CPT code 38242, Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusions, which was reviewed by the RUC in April 2002 also supports the median RVU for 38230. 38242 has a work RVU of 1.71 and pre, intra and post times of 30, 30, and 20 minutes respectively. The intra time of 38230 is three times longer than that of 38242.

We also note that current work RVU of 38230 is 4.85 which is for a 10 day global and include a post operative visit valued at 99213 or 0.97 work RVUs. Subtracting 0.97 from 4.85 leaves 3.88. Note that same day post op work for 38230 is included in this code.

Therefore, the median of 4.0 is well supported by services within the same family.

Below we discuss a number of codes that support our work RVU request. However, we would like to specifically discuss the basis for the requested increment between this code and 38232, which is 0.5 work RVUs. Even though the intraservice times for 38232 and 38230 in the surveys were similar, the intra-service work of 38230 is more intense and stressful because it is necessary to manage the donor while performing a procedure that is NOT for the donor's benefit. In fact, while performing the procedure and collecting marrow, it is the recipient's needs that must be kept in mind. The need to obtain more cells because of the risk of graft rejection, graft vs. host disease and ABO mismatching as well as the need to accommodate cell loss at the time of removal and when the cells are processed increases the stress and intensity of the procedure. Additionally, we believe that the respondents may have underestimated the intra-service time for 38230 because allogeneic donors are either unrelated donors, mismatched related donors, or matched sibling donors which, as described above, mean a much higher cell dose from the donor is required, thus requiring longer operative time for harvesting than with an autologous harvest. Therefore, we are unclear as to why the survey times came out similarly.

With respect to services outside of this family, we reviewed the following codes which support our request:

000 Globals - all have been reviewed by the RUC.

- 36556, Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older. This 000 global code has a work RVU of 2.5 with pre, intra and post times of 25, 15 and 10 minutes respectively. This is an MPC code.
- 32603, Thoracoscopy, diagnostic (separate procedure); pericardial sac, without biopsy. This 000 global code has a work RVU of 7.8 with pre, intra and post times of 83, 90 and 120 minutes respectively. This is an MPC code.
- 43240, Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transmural drainage of pseudocyst. This 000 global code has a work RVU of 6.85 and pre, intra and post times of 20, 90 and 20 minutes respectively. This is an MPC code.
- 45380, Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple. This code has a work RVU of 4.43 and pre, intra and post times of 45, 51.5 and 22 minutes respectively. This code is an MPC code.

- 31638, Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilation as required). This code has a work RVU of 4.88 and pre, intra and post times of 50, 60 and 30 minutes respectively.
- 52001, Cystourethroscopy with irrigation and evacuation of multiple obstructing clots. This code has a work RVU of 5.44 and pre, intra and post times of 50, 60 and 20 minutes respectively.

XXX Globals - all have been reviewed by the RUC.

- 99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; a comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family. This XXX global code has a work RVU of 3.17 and pre, intra and post times of 7, 45 and 15 minutes respectively. This is an MPC code.
- 99223, Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit. This XXX global code has a work RVU of 3.86 and pre, intra and post times of 15, 55 and 20 minutes respectively. This code has an IWPUT of 0.05559 which is about two and one half times the requested IWPUT for 3823X1. This is an MPC code.
- 99327, Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver. This XXX global code has a work RVU of 3.46 and pre, intra and post times of 15, 60 and 25 minutes respectively
- 95978, Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour. This XXX global code has a work RVU of 3.5 and pre, intra and post times of 5, 60 and 5 minutes respectively.
- 91110, Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with physician interpretation and report. This code has a work RVU of 3.64 and pre, intra and post times of 5, 80 and 15 minutes respectively.
- 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes. This code has a work RVU of 4.5 and pre, intra and post times of 15, 40 and 15 minutes respectively. Note that this code has an IWPUT of 0.0957 which is about four times the recommended IWPUT for 3823X1.

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) 38230

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 Hematology/Oncology How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Pediatrics How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1800

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. There are approximately 6,000 allogeneic transplants per year in the United States and an estimated 30% of those utilize bone marrow for the cell source.

Specialty Hematology/Oncology Frequency 1000 Percentage 55.55 %

Specialty Medical Oncology Frequency 400 Percentage 22.22 %

Specialty Internal Medicine Frequency 400 Percentage 22.22 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. With the split in codes, we estimate that 400 services will be reported in the 3823X1 code.

Specialty Hematology/Oncology Frequency 200 Percentage 50.00 %

Specialty Medical Oncology Frequency 100 Percentage 25.00 %

Specialty Internal Medicine Frequency 100 Percentage 25.00 %

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

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. 38230

	A	B	C	J	K	L	M	N	O
1	AMA/Specialty Society RVS Update Committee Recomm			F3		F4		F5	
2	Meeting Date: February 2011			38232		38230		38240	
3	Bone Marrow Stem Cell Revisions			Bone marrow harvesting for transplantation; autologous		F3 Bone marrow harvesting for transplantation; allogeneic		Bone marrow or blood-derived peripheral stem cell transplantation; per allogeneic donor	
4	LOCATION	Code	Staff Type	Non-Facility	Facility	Non-Facility	Facility	Non-Facility	Facility
5	GLOBAL PERIOD			000	000	000	000	XXX	XXX
6	TOTAL CLINICAL LABOR TIME			n/a	0	n/a	0	n/a	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			n/a	0	n/a	0	n/a	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			n/a	0	n/a	0	n/a	0
9	TOTAL POST-SERV CLINICAL LABOR TIME			n/a	0	n/a	0	n/a	0
10	PRE-SERVICE								
11	Start: Following visit when decision for surgery or procedure made								
12	Complete pre-service diagnostic & referral forms			0	0	0	0	0	0
13	Coordinate pre-surgery services			0	0	0	0	0	0
14	Schedule space and equipment in facility			0	0	0	0	0	0
15	Provide pre-service education/obtain consent			0	0	0	0	0	0
16	Follow-up phone calls & prescriptions			0	0	0	0	0	0
17	Other Clinical Activity:coordination of care			0	0	0	0	0	0
18	End:When patient enters office/facility for surgery/procedure								
19	SERVICE PERIOD								
20	Start: When patient enters site for procedure: Services Prior to Procedure								
39									
40	Discharge day management			0	0	0	0	0	0
42	End: Patient leaves office								
43	POST-SERVICE Period								
44	Start: Patient leaves office/facility								
45	Conduct phone calls/call in prescriptions								
46	<i>Office visits:</i>								
47	<i>List Number and Level of Office Visits</i>								
48	99211	16 minutes	16						
49	99212	27 minutes	27						
50	99213	36 minutes	36						
51	99214	53 minutes	53						
52	99215	63 minutes	63						
53	Other								
54	Total Office Visit Time			0	0	0	0	0	0
55	Other Total:								
56	End: with last office visit before end of global period								
57	MEDICAL SUPPLIES	Code	Unit						
58	None								
59									
60	Equipment	Code							
61	None								
62									

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment - Harvard Valued – Utilization over 100,000 Screen

October 2010

Abdominal Paracentesis

In February 2010, the RUC identified CPT codes 49080 *Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial* and 49081 *Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent* through the Harvard Valued-Utilization over 100,000 screen. The specialties noted that the services have evolved since the codes were initially established and need separate codes that distinguish paracentesis performed without imaging guidance and paracentesis performed with imaging guidance. In June 2010, the CPT Editorial Panel deleted two codes and created three new CPT codes, 49082, 49083 and 49084, to more accurately describe the current medical practice.

49082 Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance

The RUC reviewed the survey results for CPT code 49082. The RUC analyzed the survey's estimated physician work and noted that there is no compelling evidence to change the current work value of 1.35 for CPT code 49080, which the surveyed code is replacing. The RUC agreed with the specialty recommended pre-service time of 20 minutes, intra-service time of 20 minutes and post service time of 10 minutes for consistency with the physician time for now deleted codes 49080 (pre-service time of 26 minutes, intra-service time of 27 minutes) and 49081 (pre-service time of 25 minutes and intra-service time of 27 minutes). This time also maintains appropriate relativity across the family of services, as the RUC recommends intra-service time of 25 minutes for CPT code 49083, which is the same procedure as 49082 but with imaging guidance included. To further justify the recommended value, the RUC compared the surveyed code to key reference service CPT code 99233 *Subsequent hospital care* (work RVU= 2.00 and total time= 55 minutes). The RUC agreed that the reference code should be valued higher due to greater intra-service time compared to the surveyed code, 30 minutes and 20 minutes, respectively. The survey respondents indicated, and the RUC agreed, that the reference code requires greater mental effort and judgment compared to CPT code 49082. In addition, the RUC compared code 49082 to MPC code 11755 *Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds)* (work RVU= 1.31 and total time= 25 minutes). The RUC agreed that these services should be valued similarly, given their analogous total times, 55 minutes and 50 minutes, respectively. **The RUC recommends a work RVU of 1.35 for CPT code 49082.**

49083 Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance

The RUC reviewed and agreed with the specialty survey results from 75 radiologists, interventional radiologists and gastroenterologists for CPT code 49083. The RUC recommends pre-service time of 25 minutes, intra-service time of 25 minutes and post service time of 10 minutes. The RUC analyzed the survey's estimated physician work and agreed that the data supports a work value of 2.00, the survey's 25th percentile, which is lower than the current value for this service, CPT code 49080 (work RVU= 1.35) with code 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* (work RVU= 0.67) for a total RVU of 2.02. To further justify this recommended value, the RUC compared the surveyed code to key reference service CPT code 32422 *Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed* (work RVU= 2.19 and total time= 75 minutes). The RUC agreed that the reference code should be valued higher due to greater intra-service time than the surveyed code, 31 minutes and 25 minutes, respectively. In addition, the RUC compared CPT code 49083 to the reference MPC code 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* (work RVU= 2.39 and total time= 63 minutes). The RUC noted that the reference code should be valued greater than the surveyed code due to greater total time, 63 minutes compared to 60 minutes, and greater physician work intensity. Finally, the RUC noted that a work RVU of 2.00 for CPT code 49083 maintains the proper rank order with the approved base code 49082, accurately accounting for the inclusion of imaging guidance. **The RUC recommends a work RVU of 2.00 for CPT code 49083.**

49084 Peritoneal lavage, including imaging guidance, when performed

The RUC discussed the compelling evidence provided by the specialty society that incorrect assumptions were made in the previous valuation of this service because of a misleading vignette. During the Harvard review, the vignette used for code 49080 was "Initial abdominal paracentesis" and for code 49081 it was "abdominal paracentesis, subsequent." Peritoneal lavage is distinctly different from paracentesis. Diagnostic peritoneal lavage is performed in the urgent, unstable patient to assess for blood and enteric contents and to determine if exploratory surgery is required. The RUC agreed that compelling evidence had been met to change the value of performing this service.

The RUC reviewed and agreed with the specialty survey results from 35 general surgeons for CPT code 49084. The RUC recommends pre-service time of 23 minutes, intra-service time of 20 minutes and post service time of 15 minutes. The RUC analyzed the survey's estimated physician work and agreed that the data supports a work value of 2.50, the survey median, for this service. To further justify this value, the RUC compared the surveyed code to key reference CPT code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU= 2.50 and total time= 50 minutes). The RUC agreed that these service should be valued similarly due to their similar total physician time, 58 minutes and 50 minutes respectively, and intensity/complexity. In addition, the RUC compared CPT code 49084 to MPC code 52000 *Cystourethroscopy* (work RVU= 2.23 and total time= 42 minutes). The RUC noted that the surveyed code has greater intra-service time and total time compared to the reference code, 58 minutes and 42 minutes, respectively, and should be valued higher. Finally, to ensure the recommended value maintains relativity across the RBRVS, the RUC compared the surveyed code to MPC code 51102 *Aspiration of bladder; with insertion of suprapubic catheter* (work RVU= 2.70 and total time= 60 minutes). The RUC compared the total time between the two services, 58 minutes for 49084 and 60 minutes for 51102, and agreed that the reference code should be valued slightly higher. **The RUC recommends a work RVU of 2.50 for CPT code 49084.**

Practice Expense:

The RUC made substantial revisions to the direct practice expense inputs recommended by the specialties for procedures 49082-49083 to capture the typical patient service. The RUC approved the direct inputs as recommended by the specialty for code 49084.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
D 49080		Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial	000	N/A
D 49081		subsequent (If imaging guidance is performed, see 76942, 77012) (49080, 49081 have been deleted. To report, see 49082, 49083, 49084)	000	N/A
●49082	B1	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	000	1.35
●49083	B2	with imaging guidance (Do not report 49083 in conjunction with 76942, 77002, 77012, 77021)	000	2.00
●49084	B3	Peritoneal lavage, including imaging guidance, when performed (Do not report 49084 in conjunction with 76942, 77002, 77012, 77021)	000	2.50

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

CPT Code: 49082 Tracking Number B1 Specialty Society Recommended RVU: **1.35**
Global Period: 000 RUC Recommended RVU: **1.35**

CPT Descriptor: Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old male with cirrhosis and symptomatic ascites that has not responded to medical and dietary management

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 33%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- The patient's symptoms, history, and allergies are reviewed.
- Medications are reviewed, specifically potential antiplatelet or anticoagulation agents.
- Lab data is evaluated, particularly coagulation results and platelets.
- Available imaging is reviewed.
- Procedure details are discussed including pain control, and recovery time.
- Alternatives and risks are discussed with the patient and family and informed consent is reviewed.
- Confirm NPO status.
- Ensure appropriate specimen containers, and biopsy devices are available.
- Perform surgical 'time out'.

Description of Intra-Service Work:

- The patient is examined, the presence of ascites confirmed with physical examination, and an appropriate location for paracentesis is identified using palpation and percussion.
- The patient's abdomen is sterilely prepared with skin antiseptic (e.g., iodine, providine, chlorhexidine, etc.) and draped with sterile sheets.
- The skin and deeper tissues down to the peritoneum are infiltrated with a local anesthetic.
- A small incision is made.
- A needle or catheter is advanced into the peritoneal space and fluid aspirated.
- A sample of fluid is sent for laboratory analysis.

- The needle or catheter is then attached to a vacuum bottle and ascites fluid is drained.
- The catheter position is adjusted periodically as needed during ascites drainage to mitigate adherent bowel due to suction thus ensuring maximum drainage
- The needle or catheter is removed.
 - If necessary, a suture is placed.

Description of Post-Service Work:

- The patient is transferred to the recovery suite.
- Post-procedure vital signs are assessed.
- When stable for discharge, the findings are reviewed with patient and family.
- Ascites fluid analysis is reviewed.
- A report of the procedure is prepared for the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2010			
Presenter(s):	Dr. Edward Bentley, Dr. Nicholas Nickl, ASGE; Dr. Jayarani Agrawal, AGA				
Specialty(s):	Gastroenterology				
CPT Code:	49082				
Sample Size:	517	Resp N:	9	Response: 1.7 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	2.00	10.00	15.00
Survey RVW:		1.00	2.00	2.20	2.39
Pre-Service Evaluation Time:				10.00	
Pre-Service Positioning Time:				5.00	
Pre-Service Scrub, Dress, Wait Time:				5.00	
Intra-Service Time:		5.00	10.00	10.00	20.00
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		
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

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (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:

1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	49082	Recommended Physician Work RVU: 1.35			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		13.00	13.00	0.00	
Pre-Service Positioning Time:		1.00	1.00	0.00	
Pre-Service Scrub, Dress, Wait Time:		6.00	6.00	0.00	
Intra-Service Time:		20.00			
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 0.0	99239x 0.0		
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

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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99233	XXX	2.00	RUC Time

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11755	000	1.31	RUC Time	25,211

CPT Descriptor 1 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
88173	XXX	1.39	RUC Time	295,780

CPT Descriptor 2 Cytopathology, evaluation of fine needle aspirate; interpretation and report

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62270	000	1.37	RUC Time

CPT Descriptor Spinal puncture, lumbar, diagnostic

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 4 % of respondents: 44.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 49082	<u>Key Reference CPT Code:</u> 99233	<u>Source of Time</u> RUC Time
Median Pre-Service Time	20.00	10.00	
Median Intra-Service Time	20.00	30.00	
Median Immediate Post-service Time	10.00	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 Total Time	50.00	55.00
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	3.00	5.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	4.50
--	------	------

Urgency of medical decision making	3.25	3.50
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.75
--------------------------	------	------

Physical effort required	3.75	2.25
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.00
---	------	------

Outcome depends on the skill and judgment of physician	4.50	3.75
--	------	------

Estimated risk of malpractice suit with poor outcome	4.50	4.25
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.25	2.50
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Intra-Service intensity/complexity	4.00	4.25
------------------------------------	------	------

Post-Service intensity/complexity	2.75	2.00
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Additional Rationale and Comments

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

Codes 49080 and 49081 were identified by the Joint CPT/RUC Identification Workgroup as codes for which the dominant providers have changed from when originally surveyed. 49082 and 49083 were established to distinguish paracentesis without (49082) and with (49083) imaging guidance. The distinction between initial and subsequent paracentesis was

eliminated. Codes 49080 *Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial* and 49081 *Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent* were Harvard valued at RVW 1.35 and 1.26 respectively.

A multi-disciplinary survey was performed, including gastroenterologists and radiologists. Radiologists did not indicate that they performed 49082. The response rate for 49082 was low (17%, N=9), number surveyed 517. The median survey times were 20/10/10 with a range of intra-service time from 5 to 70 minutes. The survey median recommended RVW was 2.20. The respondents rated 49082 more intense than the key reference code 99233 (*Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity*) in 6 of 11 categories.

An expert panel of gastroenterologists and radiologists was convened to review the survey findings. The panel concluded that the survey response rate for 49082 was too low and the variation in intra-service times was too great. The panel concluded that the median intra-service time of 10 minutes to remove from 2 to 10 liters of ascites fluid was inappropriately short, but that the survey's pre-time of 20 minutes and post-time of 10 minutes was consistent with the times for **49080** (26/27/11) and **49081** (25/27/10). Although the median survey wRVW was 2.20 and the 25th percentile was 2.00, and 100% of the survey respondents agreed that the vignette of a patient with cirrhosis and symptomatic ascites was typical, the panel did not believe there was compelling evidence to recommend an increase in the physician work valuation of this procedure compared to code 49080, wRVW 1.35.

The panel then compared 49082 with other procedures which involved percutaneous puncture and removal / drainage of fluid, and identified code **33010**, *pericardiocentesis, initial*, wRVW 2.24, 19/24/27, code **32421** *Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent*, wRVW 1.54, 10/28/10, code **32422**, *Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)*, wRVW 2.19, 30/31/14, code **62270** *Spinal puncture, lumbar, diagnostic* (10/20/10) RVW 1.37 and code **48511**, *External drainage, pseudocyst of pancreas; percutaneous*, wRVW 3.99, 40/62/25. The panel compared the times of these procedures, along with 49080 and 49081, with the survey responses to 49082. The panel noted that code 32421 does not include image guidance. The panel then reviewed the survey findings for 4908X2 Paracentesis with image guidance, which had 75 respondents with median times of 25/25/20. Taking all these factors into consideration, the panel determined that code 33010 represented a point of comparison in terms of the pre- and intra-service physician times for 49082, and recommended a decrease in pre-service (comparing 49080 to 49082) from 26 to 20 minutes, a decrease in intra-service from 27 to 20 minutes, and a decrease in post-service from 11 to 10 minutes.

The panel considered that the work of 49082 is similar to the work of 4908X2 minus the additional work for imaging. The panel reviewed the following codes: **76937**, *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)*, RVW 0.30 4/10/0; **76946**, *Ultrasonic guidance for amniocentesis, imaging supervision and interpretation*, RVW 0.38 0/15/0; **76942**, *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*, RVW 0.67 0/30/0; **76930**, *Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation*, RVW 0.67 0/20/0; and **76998**, *Ultrasonic guidance, intraoperative*, RVW 1.20 0/29/0. The panel determined that the additional work of ultrasound visualization to perform 4908X2 was equivalent to code 76946, wRVW 0.38; backing this out of the recommended wRVW for 4908X2 would result in a value of 1.62. Given that the panel had determined that compelling evidence to increase the value of 49082 to existing code 49080 did not exist, the panel then reviewed the other ultrasound visualization codes and determined that codes 76942 and 76930, wRVU 0.67, represented a relative proxy and backed this out of 4908X2 to arrive at a RVW of 1.33. The panel then assessed whether there was compelling evidence that the work of this procedure or the complexity of patients had decreased. Noting that the technical skill, physical effort, psychological stress, intra-service intensity and post-service intensity was higher for 49082 compared to the key reference service, 99233, wRVW 2.00, the expert panel recommended that the existing wRVW for 49080, 1.35 wRVW, should be maintained for code 49082.

Comparison Code 32421 (*Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent*) has a RVW of 1.54 and does not include image guidance. Comparison Code 62270 *Spinal puncture, lumbar, diagnostic* (10/20/10) RVW 1.37 provides another key reference.

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)

49080 Peritoneocentesis, abdominal paracentesis or peritoneal lavage (diagnostic or therapeutic); initial
 49081 subsequent

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 Gastroenterology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 32000
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. RUC database frequency as reported by gastroenterology is around 8,000 and an additional estimate of 24,000 for procedures reported to private insurers.

Specialty Gastroenterology Frequency 32000 Percentage 100.00 %

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? 8,000
 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 frequency as reported by gastroenterology

Specialty Gastroenterology Frequency 8000 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? No

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 49080

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

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

CPT Code:49083 Tracking Number B2 Specialty Society Recommended RVU: **2.00**
Global Period: 000 RUC Recommended RVU: **2.00**

CPT Descriptor: Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance

Do not report 49083 in conjunction with 76942, 77002, 77012, 77021)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 59-year-old female with metastatic ovarian cancer and previously demonstrated loculated ascitic for removal for re-accumulating symptomatic ascitic fluid.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 26%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- The patient's symptoms, history, and allergies are reviewed.
- Medications are reviewed, specifically potential antiplatelet or anticoagulation agents
- Lab data is evaluated, particularly coagulation results and platelets.
- Available imaging is reviewed.
- Procedure details are discussed including pain control, and recovery time
- Alternatives and risks are discussed with the patient and family and informed consent is reviewed.
- Confirm NPO status
- Ensure imaging, appropriate specimen containers, and biopsy devices are available
- Ensure all technical personnel have been familiarized with the procedure and are fully familiar with all required devices
- Perform surgical "time out"

Description of Intra-Service Work:

- The patient is examined and the presence of ascites confirmed with physical examination.
- Ultrasound is used to interrogate the abdomen for extent and appropriate pockets of ascites, presence of echogenic complex fluid, or loculations, and identification of subjacent organs and abdominal wall vasculature. Images are recorded.

- The skin and deeper tissues down to the peritoneum are infiltrated with a local anesthetic under ultrasound guidance taking care to avoid vessels.
- A small incision is made.
- Using real-time ultrasound guidance a needle is advanced into the peritoneal space and fluid aspirated.
- A sample of fluid is sent for laboratory analysis.
- Using seldinger technique, a centesis catheter is advanced into the ascites and secured in place temporarily.
- The catheter is then attached to a vacuum bottle and a variable amount of fluid (~3-5 liters) are drained.
- The catheter position is adjusted to avoid adhering to bowel due to suction thus ensuring maximum drainage.
- Ultrasound is used to help in repositioning.

Description of Post-Service Work:

- The patient is transferred to the recovery suite
- Post-procedure vital signs are assessed
- When stable for discharge, the findings are reviewed with patient and family
- A report of the procedure is prepared for the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2010			
Presenter(s):	Zeke Silva, MD ACR, Sean Tutton, MD SIR, Bob Vogelzang, MD SIR, Jaya Agrawal, MD MPH AGA and Nicholas Nickl, MD ASGE				
Specialty(s):	Radiology, Interventional Radiology and Gastroenterology				
CPT Code:	49083				
Sample Size:	922	Resp N:	75	Response: 8.1 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		1.00	28.00	50.00	100.00
Survey RVW:		0.76	2.00	2.25	4.00
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				5.00	
Pre-Service Scrub, Dress, Wait Time:				5.00	
Intra-Service Time:		10.00	15.00	25.00	30.00
Immediate Post Service-Time:		<u>10.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (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: 1a-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	49083	Recommended Physician Work RVU: 2.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		15.00	13.00	2.00
Pre-Service Positioning Time:		5.00	1.00	4.00
Pre-Service Scrub, Dress, Wait Time:		5.00	6.00	-1.00
Intra-Service Time:		25.00		
Immediate Post Service-Time:		<u>10.00</u>		
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00

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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
32422	000	2.19	RUC Time

CPT Descriptor Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
43235	000	2.39	RUC Time	423,238

CPT Descriptor 1 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	12,781

CPT Descriptor 2 Aspiration of bladder; with insertion of suprapubic catheter 20 minutes intra

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36556	000	2.50	RUC Time

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 36 % of respondents: 48.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 49083	<u>Key Reference CPT Code:</u> 32422	<u>Source of Time</u> RUC Time
Median Pre-Service Time	25.00	30.00	
Median Intra-Service Time	25.00	31.00	
Median Immediate Post-service Time	10.00	14.00	
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 Total Time	60.00	75.00	
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	2.56	2.67
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.67	2.72
--	------	------

Urgency of medical decision making	2.44	2.69
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.75	2.75
--------------------------	------	------

Physical effort required	2.50	2.64
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.47	3.00
---	------	------

Outcome depends on the skill and judgment of physician	2.81	2.89
--	------	------

Estimated risk of malpractice suit with poor outcome	2.53	2.81
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.50	2.64
----------------------------------	------	------

Intra-Service intensity/complexity	2.89	2.94
------------------------------------	------	------

Post-Service intensity/complexity	2.47	2.72
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Additional Rationale and Comments

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

The paracentesis codes were identified by the Joint CPT/RUC Identification Workgroup as codes for which the dominant providers have changed from when these codes were originally surveyed. As a result separate codes for non image-guided (49082) and image-guided paracentesis (49083) were created. Historically these codes were created and utilized by the surgical specialties. Over time there has been a significant change in practice pattern and providers. As detailed below from the Medicare database, the majority of these procedures are now

provided by radiology, interventional radiology, and gastroenterology. The use of image guidance predominates and thus a bundled code, 49083, was created.

Survey analysis:

A random survey for 49083 was distributed to radiologists, interventionalists and gastroenterologists with an excellent response rate. An expert ACR, SIR, AGA and ASGE panel convened which determined that the median values of intraservice time of 25 minutes and RVW of 2.00 were supported by the data. The following is a rationale to support our recommendation.

Pre-service Time:

The societies chose pre-service time package 1a-FAC Straightforward Patient/Procedure (no sedation/anesthesia) with the following adjustments-Pre-service evaluation package time is increased by 2 minutes and Pre-service positioning time is increased by 4 minutes to conform to the survey result and account for time prior to skin prep used for US localization of a suitable pocket of fluid. Based on the survey instrument it is reasonable to conclude respondents would consider imaging work prior to skin prep to be pre-service work. Pre-service scrub, dress and wait time is decreased by 1 minute in accordance with the survey data. These modifications are consistent with recently reviewed IR codes including percutaneous cholecystostomy.

Reference service comparison:

Tube thoracostomy, 32422, was the most commonly chosen reference service with 31 minutes of intra-service time and RVW of 2.19. This service can be performed without or with imaging guidance. When imaging guidance is used, the service is reported with CPT code 76942 (0.67 RVU). The key reference service has 30 minutes in pre-service time but was valued prior to standardization with pre-service packages. Intraservice time is 6 minutes greater for the reference service and as expected the intensity measures are generally higher for the key reference service as well. However, when the work value of separately imaging is considered, the combined service (32422 + 76942) results in a work value of 2.86 RVU placing it in the proper rank order as compared to our recommendation for 49083 with 25 minutes intraservice time.

Another common reference service code picked by our survey respondents that most closely approximates the work RVUs was CPT code 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older*. This service has time 25 minutes of pre, 15 minutes of intra and 10 minutes of post (total 50 minutes) with an RVU of 2.50. This reference service code is in line with our recommendations as well.

MPC comparison and comparison to other codes:

Several codes are suggested as reasonable comparison codes outlined below. CPT codes 43235 and 51102 are MPC codes and both have slightly higher RVU values and slightly less intraservice time.

CPT Code	CPT Descriptor	Intra Time	RVUs
64493	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	15	1.52
64483	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	15	1.90*
49083	Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	25	2.00

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)	20	2.39
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	15	2.50
51102	Asp of bladder; with insertion of suprapubic cath	20	2.70

**RUC Recommendation October 2009 but not yet published by CMS*

Building block methodology:

It should be noted that this is a new CPT code describing a new service with change in dominant provider and service description so a direct comparison to previously reported codes 49080 and its typical imaging pair (76942) is not appropriate. As the DOW for the surveyed code would suggest, the imaging guidance prior to catheter placement to avoid injury to bowel or vessels, as well as periodic imaging during drainage to ensure optimal drainage of the ascites is distinctly different than in the past when the procedure was performed based on anatomic landmarks. Drainage is more complete and as the vignette would suggest performed in a more difficult patient with malignant ascites and loculations.

However, as a point of reference for the Panel we provide the following information:
 49080 (1.35) + 76942 (0.67) = 2.02

IWPUT:

The calculated IWPUT for the surveyed procedure 49083 is 0.0515 which aligns nicely with other similar interventional radiology procedures. For example the recently RUC surveyed code 49450 *Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* has 10 minutes of intra time and an IWPUT of 0.0536. Another recently RUC surveyed code 36147 *Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report* has an intra time of 45 minutes and an IWPUT of 0.0652.

In conclusion, we are recommending 2.00 RVUs, total time of 60 minutes (25/25/10) and an IWPUT of 0.0515. We feel that our survey data (75 respondents) supports these recommendations.

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)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 49080

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

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

CPT Code:49084 Tracking Number B3 Specialty Society Recommended RVU: **2.50**
Global Period: 000 RUC Recommended RVU: **2.50**

CPT Descriptor: Peritoneal lavage, including imaging guidance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male is seen in the emergency room, hemodynamically unstable with multiple trauma following a motor vehicle collision. Peritoneal lavage is performed to assess for blood, the presence of enteric contents, and for further laboratory analysis.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Explain procedure to patient. Review risks and complications. Obtain consent if able. Mark operative site. Verify that all required instruments and supplies are available. Drape and prep site. Local anesthetic is administered. Scrub and gown. Perform "time out."

Description of Intra-Service Work: a vertical skin incision is made one third of the distance from the umbilicus to the symphysis pubis (above the umbilicus if pelvic fracture is suspected). The linea alba is divided and the peritoneum entered after it has been picked up to prevent bowel perforation. A catheter is inserted towards the pelvis and aspiration of material attempted using a syringe. If no blood is aspirated, 1 litre of warm 0.9% saline is infused. Five minutes are allowed for equilibration. The IV bag is then lowered to allow for retrieval of intraperitoneal fluid via siphoning effect. Altering position of patient/catheter is performed to maximize retrieval of effluent. Effluent is sent for analysis.

Description of Post-Service Work: Apply appropriate sterile dressing. Write orders for pain medication, as appropriate. Dictate operative report and complete medical record documentation. The patient will be triaged based on the traumatic injuries and the macroscopic/microscopic result of the lavage. Dictate progress notes for medical record with copy to PCP.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		10/2010			
Presenter(s):	Christopher Senkowski, MD, FACS; Samuel Smith, MD, FACS				
Specialty(s):	general surgery				
CPT Code:	49084				
Sample Size:	100	Resp N:	35	Response: 35.0 %	
Sample Type:	Panel Additional Sample Information: both random ACS member selection and members of the ACS Committee on Trauma				
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		1.00	1.00	4.00	5.00
Survey RVW:		1.82	2.45	2.50	3.00
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				5.00	
Pre-Service Scrub, Dress, Wait Time:				5.00	
Intra-Service Time:		15.00	15.00	20.00	25.00
Immediate Post Service-Time:		<u>15.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	49084	Recommended Physician Work RVU: 2.50		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		15.00	40.00	-25.00
Pre-Service Positioning Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress, Wait Time:		5.00	20.00	-15.00
Intra-Service Time:		20.00		
Immediate Post Service-Time:		<u>15.00</u>		
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
			57x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
36556	000	2.50	RUC Time

CPT Descriptor Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
52000	000	2.23	RUC Time	926,353
<u>CPT Descriptor 1</u> Cystourethroscopy (separate procedure)				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
51102	000	2.70	RUC Time	12,781

CPT Descriptor 2 Aspiration of bladder; with insertion of suprapubic catheter

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 15 % of respondents: 42.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 49084	<u>Key Reference CPT Code:</u> 36556	<u>Source of Time</u> RUC Time
Median Pre-Service Time	23.00	25.00	
Median Intra-Service Time	20.00	15.00	
Median Immediate Post-service Time	15.00	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 Total Time	58.00	50.00	
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	3.19	2.69
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.25	3.06
--	------	------

Urgency of medical decision making	4.19	3.00
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.31	3.13
--------------------------	------	------

Physical effort required	2.63	2.69
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.56	3.44
---	------	------

Outcome depends on the skill and judgment of physician	3.50	3.63
--	------	------

Estimated risk of malpractice suit with poor outcome	3.88	3.75
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.38	2.88
----------------------------------	------	------

Intra-Service intensity/complexity	2.94	3.13
------------------------------------	------	------

Post-Service intensity/complexity	2.56	2.50
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Additional Rationale and Comments

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

Background

Code 49080 was identified in October 2009 by the RUC 5-Year-Review ID Workgroup through the Harvard Valued - Utilization Over 100,000 screen. An Action Plan was submitted by AGA and ASGE that indicated the primary provider has evolved from gastroenterology to radiology. A request was made to revise 49080 at CPT to better define the work of all providers. The RUC agreed and a Coding Change Proposal was submitted that proposed deletion of 49080 and

36556	2.50	50	15	5	5	15	10
49084	2.50	58	15	3	5	20	15

Comparison to MPC codes with 000-global period

RUC/MPC	CPT	DESC	RVW	TOT MIN	EVAL	POSIT	SDW	INTRA	POST
2006	54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	45	15	5	5	15	5
2005	52000	Cystourethroscopy (separate procedure)	2.23	42	10	2	5	15	10
2005	43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	2.39	63	18	5	5	20	15
	49084	Peritoneal lavage, including imaging guidance, when performed	2.50	58	15	3	5	20	15
2003	36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	2.50	50	15	5	5	15	10
2008	51102	Aspiration of bladder; with insertion of suprapubic catheter	2.70	60	19	1	5	20	15
2005	31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	2.78	65	10	5	5	30	15
2000	43239	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple	2.87	85	27			34	24
2005	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)	3.69	75	20	5	5	30	15

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. These patients are trauma victims and will require the attention of multiple health care providers.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 49080, 49080-22

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 general surgery

How often? Sometimes

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? 4,200

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimated by consensus panel based on 2009 Medicare frequency for general surgeons for 49080

Specialty	Frequency	Percentage
general surgery	4200	100.00 %

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Do many physicians perform this service across the United States?

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 49080

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Surgical

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

CPT Long Descriptor:

Abdominal paracentesis (diagnosis or therapeutic); without imaging guidance

Global Period: 000

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

Representatives from the American Gastroenterological Association's Practice Management and Economics Committee and the American Society for Gastrointestinal Endoscopy's Practice Management Committee, other members of our societies who have expertise in coding, coverage and payment issues, and ad hoc members who have expertise with this procedure, comprise the "Gastroenterology Specialty Societies RBRVS and Practice Expense Committee". This committee met by conference call to discuss and develop our PE recommendations for this code.

The recommendations were developed through a combination of survey data review and recommendations from an expert panel highly familiar with the procedure.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Pre-service diagnostic and referral forms are completed
- Obtain and Review charts
- Greet patient and provide gowning
- Prepare room, equipment, supplies
- Obtain vital signs
- Instructions and pre-procedure education are provided to the patient and family
- Have patient sign consent
- Prepare and position patient/ monitor patient

Intra-Service Clinical Labor Activities:

- Assist physician in performing procedure
- Monitor patient including vital signs

Post-Service Clinical Labor Activities:

- Monitor patient following service/check dressings, monitors
- Clean room
- Complete diagnostic forms, lab & X-ray requisitions
- Review/read X-ray, lab, and pathology reports
- Check dressings & wound/home care instructions/coordinate office visits/prescriptions
- Conduct phone calls/call-in prescriptions

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

CPT Long Descriptor:

Abdominal paracentesis (diagnosis or therapeutic); without imaging guidance

Global Period: 000

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

Representatives from the American Gastroenterological Association's Practice Management and Economics Committee and the American Society for Gastrointestinal Endoscopy's Practice Management Committee, other members of our societies who have expertise in coding, coverage and payment issues, and ad hoc members who have expertise with this procedure, comprise the "Gastroenterology Specialty Societies RBRVS and Practice Expense Committee". This committee met by conference call to discuss and develop our PE recommendations for this code.

The recommendations were developed through a combination of survey data review and recommendations from an expert panel highly familiar with the procedure.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Pre-service diagnostic and referral forms are completed
- Services are coordinated to schedule the procedures with the patient and family
- Space and equipment are scheduled
- Instructions and pre-procedure education are provided to the patient and family
- Follow up instructions and appointments are provided and scheduled

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

None

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation								
2				49082				49083	
3	September 2010 RUC meeting:	CMS Description	CMS Code	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance		CMS Description	CMS Code	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	
4	LOCATION			Non Facility	Facility			Non Facility	Facility
5	GLOBAL PERIOD			0	0			0	0
6	TOTAL CLINICAL LABOR TIME			53.0	20.0			81.0	20.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			4.0	17.0			7.0	17.0
8		RN/LPN/MTA	L037D	4.0	17.0	RN/LPN/MTA	L037D	4.0	12.0
9						RDMS	L051B	3.0	5.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			46.0	0.0			71.0	0.0
11		RN/LPN/MTA	L037D	46.0		RN/LPN/MTA	L037D	31.0	
12						RDMS	L051B	40.0	
13	TOTAL POST-SERV CLINICAL LABOR TIME	RN/LPN/MTA	L037D	3.0	3.0	RN/LPN/MTA	L037D	3.0	3.0
14	PRE-SERVICE								
15	Start: Following visit when decision for surgery or procedure made								
16	Complete pre-service diagnostic & referral forms	RN/LPN/MTA	L037D	3	3	RN/LPN/MTA	L037D	3	3
17	Coordinate pre-surgery services	RN/LPN/MTA	L037D	1	1	RN/LPN/MTA	L037D	1	1
18	Schedule space and equipment in facility	RN/LPN/MTA	L037D		5	RDMS	L051B		5
19	Provide pre-service education/obtain consent	RN/LPN/MTA	L037D		5	RN/LPN/MTA	L037D		5
20	Follow-up phone calls & prescriptions	RN/LPN/MTA	L037D		3	RN/LPN/MTA	L037D		3
21	Other Clinical Activity (please specify)								
22	- Retrieve prior lab tests, clinical notes, and appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information					RDMS	L051B	3	
23	End:When patient enters office/facility for surgery/procedure								
24	SERVICE PERIOD - PLEASE SEE LINE 99 For Explanation								
25	Start: When patient enters office/facility for surgery/procedure								
26	Pre-service services								
27	Greet patient, provide gowning, ensure appropriate medical records are available	RN/LPN/MTA	L037D	3		RN/LPN/MTA	L037D	3	
28	Obtain vital signs	RN/LPN/MTA	L037D	3		RN/LPN/MTA	L037D	3	
29	Provide pre-service education/obtain consent	RN/LPN/MTA	L037D	3		RN/LPN/MTA	L037D	3	
30	Prepare room, equipment, supplies	RN/LPN/MTA	L037D	2		RDMS	L051B	2	
31	Setup scope (non facility setting only)								
32	Prepare and position patient/ monitor patient/ set up IV	RN/LPN/MTA	L037D	2		RDMS	L051B	2	
33	Sedate/apply anesthesia								
34	Intra-service								
35									
36	Assist physician in performing procedure	RN/LPN/MTA	L037D	10		RDMS	L051B	20	
37	Monitor drainage of fluid	RN/LPN/MTA	L037D	10		RN/LPN/MTA	L037D	15	
38	Image Acquisition					RDMS	L051B	5	
39	Post-Service								
40	Monitor pt. following service/check tubes, monitors, drains	RN/LPN/MTA	L037D	4		RN/LPN/MTA	L037D	4	
41	Clean room/equipment by physician staff	RN/LPN/MTA	L037D	3		RDMS	L051B	3	
42	Clean Scope								
43	Clean Surgical Instrument Package								
44	Complete diagnostic forms, lab & X-ray requisitions	RN/LPN/MTA	L037D	3		RDMS	L051B	3	
45	Review/read X-ray, lab, and pathology reports								
46	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	RN/LPN/MTA	L037D	3		RN/LPN/MTA	L037D	3	
47	Discharge day management 99238 --12 minutes 99239 --15 minutes								
48	Other Clinical Activity (please specify)								
49	- Process films, hang films and review study with interpreting MD prior to patient discharge					RDMS	L051B	5	
50	End: Patient leaves office								
51	POST-SERVICE Period								
52	Start: Patient leaves office/facility								
53	Conduct phone calls/call in prescriptions	RN/LPN/MTA	L037D	3	3	RN/LPN/MTA	L037D	3	3
64	Other Activity (please specify)								
65	End: with last office visit before end of global period								

	A	B	C	D	E	F	G	H	I
2				49082				49083	
3	September 2010 RUC meeting:	CMS Description	CMS Code	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance		CMS Description	CMS Code	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	
4	LOCATION			Non Facility	Facility			Non Facility	Facility
66	MEDICAL SUPPLIES								
67	PEAC multispecialty supply package	SA048		1		SA048		1	
68	Thoracentesis tray with catheter	SA070		1		SA070		1	
69	Thoracentesis bottles, vacuum	SD010		5		SD010		5	
70	Sterile gloves	SB024		1		SB024		2	
71	Chux	SB044		1		SB044		1	
72	Mask with face shield	SB034		2		SB034		2	
73	Sterile Drape for Mayo Stand	SB012		1		SB012		1	
74	cover-condom, transducer or ultrasound probe					SB005		1	
75	lubricating jelly (Surgilube)					SJ033		30	
76	Disinfectant					SM012		10	
77	sanitizing cloth-wipe (patient)					SM021		2	
78	Film jacket or jacket insert					No code		0	
79	Film, 14x17, laser					SK098		1	
80	Film, 8x10 color					SK022		2	
81	Processor chemicals							0	
82	DO NOT INCLUDE THE FOLLOWING INPUTS IN X1 or X2								
83	Gauze, 4x4								
84	Tape								
85	Betadine								
86	Patient gown								
87	bandaid								
88	Gloves, non-sterile								
89	Pillow case, disposable								
90	Equipment								
91	Power Exam Table	EF031		62		EF031		86	
92	Mayo Stand	EF015		62		EF015		86	
93	Exam Lamp	EQ168		62		EQ168		86	
94	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		62		EQ011		86	
95	Ultrasound Room					EL015		86	
96	film alternator					ER029		86	
97	laser printer					no code		10	
98									
99									
100	During discussion of 49083, which represented a combination of 49080 and 76942, line 37 "assist physician in image acquisition" preserved 5 minutes of input while reference code 76942 previously had an input of 45 minutes. This did not reflect an absolute reduction crosswalk but rather represented additional staff imaging acquisition time which was not duplicate and not captured elsewhere in line inputs. Imaging work was redistributed throughout other clinical activities.								

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation								
2				49082				49083	
3	September 2010 RUC meeting:	CMS Description	CMS Code	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance		CMS Description	CMS Code	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	
4	LOCATION			Non Facility	Facility			Non Facility	Facility
5	GLOBAL PERIOD			0	0			0	0
6	TOTAL CLINICAL LABOR TIME			69.0	20.0			96.0	20.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			4.0	17.0			7.0	17.0
8		RN/LPN/MTA	L037D	4.0	17.0	RN/LPN/MTA	L037D	4.0	12.0
9						RDMS	L051B	3.0	5.0
10	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			62.0	0.0			86.0	0.0
11		RN/LPN/MTA	L037D	62.0		RN/LPN/MTA	L037D	31.0	
12						RDMS	L051B	55.0	
13	TOTAL POST-SERV CLINICAL LABOR TIME	RN/LPN/MTA	L037D	3.0	3.0	RN/LPN/MTA	L037D	3.0	3.0
14	PRE-SERVICE								
15	Start: Following visit when decision for surgery or procedure made								
16	Complete pre-service diagnostic & referral forms	RN/LPN/MTA	L037D	3	3	RN/LPN/MTA	L037D	3	3
17	Coordinate pre-surgery services	RN/LPN/MTA	L037D	1	1	RN/LPN/MTA	L037D	1	1
18	Schedule space and equipment in facility	RN/LPN/MTA	L037D		5	RDMS	L051B		5
19	Provide pre-service education/obtain consent	RN/LPN/MTA	L037D		5	RN/LPN/MTA	L037D		5
20	Follow-up phone calls & prescriptions	RN/LPN/MTA	L037D		3	RN/LPN/MTA	L037D		3
21	Other Clinical Activity (please specify)								
22	- Retrieve prior lab tests, clinical notes, and appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information					RDMS	L051B	3	
23	End:When patient enters office/facility for surgery/procedure								
24	SERVICE PERIOD - PLEASE SEE LINE 99 For Explanation								
25	Start: When patient enters office/facility for surgery/procedure								
26	Pre-service services								
27	Greet patient, provide gowning, ensure appropriate medical records are available	RN/LPN/MTA	L037D	3		RN/LPN/MTA	L037D	3	
28	Obtain vital signs	RN/LPN/MTA	L037D	3		RN/LPN/MTA	L037D	3	
29	Provide pre-service education/obtain consent	RN/LPN/MTA	L037D	3		RN/LPN/MTA	L037D	3	
30	Prepare room, equipment, supplies	RN/LPN/MTA	L037D	2		RDMS	L051B	5	
31	Setup scope (non facility setting only)								
32	Prepare and position patient/ monitor patient/ set up IV	RN/LPN/MTA	L037D	3		RDMS	L051B	6	
33	Sedate/apply anesthesia								
34	Intra-service								
35									
36	Assist physician in performing procedure	RN/LPN/MTA	L037D	20		RDMS	L051B	25	
37	Monitor drainage of fluid	RN/LPN/MTA	L037D	15		RN/LPN/MTA	L037D	15	
38	Image Acquisition					RDMS	L051B	5	
39	Post-Service								
40	Monitor pt. following service/check tubes, monitors, drains	RN/LPN/MTA	L037D	4		RN/LPN/MTA	L037D	4	
41	Clean room/equipment by physician staff	RN/LPN/MTA	L037D	3		RDMS	L051B	6	
42	Clean Scope								
43	Clean Surgical Instrument Package								
44	Complete diagnostic forms, lab & X-ray requisitions	RN/LPN/MTA	L037D	3		RDMS	L051B	3	
45	Review/read X-ray, lab, and pathology reports								
46	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	RN/LPN/MTA	L037D	3		RN/LPN/MTA	L037D	3	
47	Discharge day management 99238 --12 minutes 99239 --15 minutes								
48	Other Clinical Activity (please specify)								
49	- Process films, hang films and review study with interpreting MD prior to patient discharge					RDMS	L051B	5	
50	End: Patient leaves office								
51	POST-SERVICE Period								
52	Start: Patient leaves office/facility								
53	Conduct phone calls/call in prescriptions	RN/LPN/MTA	L037D	3	3	RN/LPN/MTA	L037D	3	3
64	Other Activity (please specify)								
65	End: with last office visit before end of global period								

	A	B	C	D	E	F	G	H	I
2				49082				49083	
3	September 2010 RUC meeting:	CMS Description	CMS Code	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance		CMS Description	CMS Code	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	
4	LOCATION			Non Facility	Facility			Non Facility	Facility
66	MEDICAL SUPPLIES								
67	PEAC multispecialty supply package	SA048		1		SA048		1	
68	Thoracentesis tray with catheter	SA070		1		SA070		1	
69	Thoracentesis bottles, vacuum	SD010		5		SD010		5	
70	Sterile gloves	SB024		1		SB024		2	
71	Chux	SB044		1		SB044		1	
72	Mask with face shield	SB034		2		SB034		2	
73	Sterile Drape for Mayo Stand	SB012		1		SB012		1	
74	cover-condom, transducer or ultrasound probe					SB005		1	
75	lubricating jelly (Surgilube)					SJ033		30	
76	Disinfectant					SM012		10	
77	sanitizing cloth-wipe (patient)					SM021		2	
78	Film jacket or jacket insert					No code		1	
79	Film, 14x17, laser					SK098		1	
80	Film, 8x10 color					SK022		2	
81	Processor chemicals							1	
82	DO NOT INCLUDE THE FOLLOWING INPUTS IN X1 or X2								
83	Gauze, 4x4								
84	Tape								
85	Betadine								
86	Patient gown								
87	bandaid								
88	Gloves, non-sterile								
89	Pillow case, disposable								
90	Equipment								
91	Power Exam Table	EF031		62		EF031		86	
92	Mayo Stand	EF015		62		EF015		86	
93	Exam Lamp	EQ168		62		EQ168		86	
94	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		62		EQ011		86	
95	Ultrasound Room					EL015		86	
96	film alternator					ER029		86	
97	laser printer					no code		10	
98									
99									
100	During discussion of 49083, which represented a combination of 49080 and 76942, line 37 "assist physician in image acquisition" preserved 5 minutes of input while reference code 76942 previously had an input of 45 minutes. This did not reflect an absolute reduction crosswalk but rather represented additional staff imaging acquisition time which was not duplicate and not captured elsewhere in line inputs. Imaging work was redistributed throughout other clinical activities.								

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

CPT Long Descriptor:

Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance

Global Period

000

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

The ACR and SIR convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- Schedule space and equipment in facility
- Provide pre-service education/ obtain consent
- Follow-up phone calls and prescriptions

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

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

CPT Long Descriptor:

Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance

Global Period

000

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

The ACR and SIR convened a group from a broad range of geographic locations with differing practice circumstances and settings, who typically perform this service. The committee served as the consensus panel to finalize these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms
- Coordinate pre-surgery services
- 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, provide gowning, ensure appropriate medical records are available
- Obtain vital signs
- Provide pre-service education/ obtain consent
- Prepare room, equipment and supplies
- Prepare and position patient/ monitor patient/ set up IV
- Assist physician in performing procedure
- Assist physician with image acquisition
- Monitor patient following service/ check tubes, monitors, drains
- Clean room/equipment by physician staff
- Clean surgical instrument package
- Complete diagnostic forms, lab and x-ray requisitions
- Check dressing and wound/home care instructions/ coordinate office visits/prescriptions
- Process films, hang films and review study with interpreting MD prior to patient discharge

Post-Service Clinical Labor Activities:

- Conduct phone calls /call in prescriptions

**AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
000, 010, or 090 Day Global Periods
Direct Inputs**

CPT Long Descriptor:

GLOBAL	CPT	DESCRIPTOR
000	49084	Peritoneal lavage, including imaging guidance, when performed

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

A panel of general surgeons considered the direct practice expense inputs related to 49084 and recommend no inputs for this emergent procedure that should be a facility only code.

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
1	AMA Specialty Society RVS Update Committee			B3	
2	Meeting Date: Oct 2010			49084	
3				Peritoneal lavage, including imaging guidance, when performed	
4	LOCATION	Code	Staff Type	OFF	FAC
5	GLOBAL PERIOD			000	000
6	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0
7	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0
9	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	n/a	0
10	PRE-SERVICE				
11	Start: Following visit when decision for surgery or procedure made			n/a	
12	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA	n/a	0
13	Coordinate pre-surgery services	L037D	RN/LPN/MTA	n/a	0
14	Schedule space and equipment in facility	L037D	RN/LPN/MTA	n/a	0
15	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	n/a	0
16	Follow-up phone calls & prescriptions	L037D	RN/LPN/MTA	n/a	0
17	Other Clinical Activity (please specify)	L037D	RN/LPN/MTA	n/a	0
18	End:When patient enters office/facility for surgery/procedure			n/a	
19	SERVICE PERIOD				
20	Start: When patient enters site for procedure: Services Prior to Procedure			n/a	
38	Discharge day management	L037D	RN/LPN/MTA	n/a	0
40	End: Patient leaves office			n/a	
41	POST-SERVICE Period				
42	Start: Patient leaves office/facility			n/a	
43	Conduct phone calls/call in prescriptions			n/a	0
52	Total Office Visit Time	L037D	RN/LPN/MTA	n/a	0
53	Other Total:			n/a	0
54	End: with last office visit before end of global period			n/a	
55	MEDICAL SUPPLIES	Code	Unit		
56	Equipment	Code			

AMA/Specialty Society RVS Update Committee Summary of Recommendations

February 2011

Percutaneous Laminotomy Disc Procedure

At the October 2010 Meeting, the CPT Editorial Panel editorially revised 62287 as there was some confusion by providers of the service about whether imaging guidance is included in the procedure. When 62287 was reviewed by the RUC in 1995, the valuation included the performance of percutaneous discectomy utilizing imaging guidance. Therefore, the specialties recommended and the CPT Editorial Panel agreed that the descriptor and subsequent parentheticals be editorially revised to reflect the inclusion of imaging guidance. Provided this history, the RUC agreed with the specialty societies that this revision to the coding language was editorial and recommends that the value for 62287 be maintained. Further, the RUC recommends that a CPT Assistant Article be written by the specialty societies to educate their membership on appropriate coding for this procedure. **The RUC recommends 9.03 work RVUs, the current work RVU, for CPT code 62287.**

Work Neutrality

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

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p><i>Injection of contrast during fluoroscopic guidance and localization is an inclusive component of 62263, 62264, 62267, 62270-62273, 62280-62282, 62310-62319. Fluoroscopic guidance and localization is reported with 77003, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes.</i></p> <p><i>For radiologic supervision and interpretation of epidurography, use 72275. Code 72275 is only to be used when an epidurogram is performed, images documented, and a formal radiologic report is issued.</i></p> <p><i>Code 62263 describes a catheter-based treatment involving targeted injection of various substances (eg, hypertonic saline, steroid, anesthetic) via an indwelling epidural catheter. Code 62263 includes percutaneous insertion and removal of an epidural catheter (remaining in place over a several-day period), for the administration of multiple injections of a neurolytic agent(s) performed during serial treatment sessions (ie, spanning two or more treatment days). If required, adhesions or scarring may also be lysed by mechanical means. Code 62263 is not reported for each adhesiolysis treatment, but should be reported once to describe the entire series of injections/infusions spanning two or</i></p>				

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p><i>more treatment days.</i></p> <p><i>Code 62264 describes multiple adhesiolysis treatment sessions performed on the same day. Adhesions or scarring may be lysed by injections of neurolytic agent(s). If required, adhesions or scarring may also be lysed mechanically using a percutaneously-deployed catheter.</i></p> <p>Codes 62263 and 62264 include the procedure of injections of contrast for epidurography (72275) and fluoroscopic guidance and localization (77003) during initial or subsequent sessions.</p>				
▲62287	N1	<p>Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single <u>utilizing needle based technique to remove disc material under fluoroscopic imaging or multiple levels</u> other form of indirect visualization, lumbar (eg with the use of an endoscope, manual with discography and/or automated percutaneous discectomy) <u>epidural injection(s) at the treated level(s), when performed, percutaneous laser discectomy</u> single or multiple levels, lumbar</p> <p><u>(This includes endoscopic approach)</u></p> <p>(For fluoroscopic guidance, use 77003)</p> <p><u>(Do not report 62287 in conjunction with 62267, 62310, 62311, 62290, 77003, 77012, 72295, when performed at same level)</u></p> <p>(For injection of non neurolytic diagnostic or therapeutic substance(s), see 62310, 62311)</p> <p><u>(For non-needle based technique for percutaneous decompression of nucleus pulposus of intervertebral disc, see codes 0276T, 0277T)</u></p>	090	9.03 (No Change)
<p>Surgery Nervous System Spine and Spinal Cord Posterior Extradural Laminotomy or Laminectomy for Exploration/Decompression of Neural Elements or Excision of Herniated Intervertebral Discs</p>				

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<u>Endoscopically assisted laminotomy (hemilaminectomy) requires open and direct visualization. When visualization is only endoscopic and/or image guidance the procedure is percutaneous and reported using 0274T, 0275T.</u>				
E 63020		Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches ; 1 interspace, cervical (For bilateral procedure, report 63020 with modifier 50)	090	16.20 (No Change)
E 63030		1 interspace, lumbar (For bilateral procedure, report 63030 with modifier 50)	090	13.18 (No Change)
E +63035	ZZZ	each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure) (Use 63035 in conjunction with 63020-63030) (For bilateral procedure, report 63035 with modifier 50) <u>(For percutaneous endoscopic approach, see 0274T, 0275T)</u>	ZZZ	3.15 (No Change)
Category III				
•0276T		Percutaneous laminotomy/laminectomy (intradiscal approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic		N/A
•0277T		lumbar (For laminotomy/hemilaminectomy performed using an open and endoscopically-assisted approach, see 63020-63035) (For percutaneous decompression of the nucleus pulposus of intervertebral disc		N/A

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		utilizing needle based technique, use 62287)		



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January 7, 2011

Barbara Levy, MD
Chair, AMA/Relative Value Update Committee
American Medical Association
515 N. State Street
Chicago, IL 60654

Dear Dr. Levy:

The North American Spine Society (NASS) is writing at the request of AMA staff to provide additional information on the recent editorial change to code 62287 for percutaneous discectomy that the CPT Editorial Panel approved in October 2010.

Imaging guidance is not bundled into the editorially revised code and should be billed separately when appropriate. The most recent data from the Medicare database indicate that code 62287 is billed with CT guidance (code 77012) 29% of the time and with fluoroscopic guidance (code 77003) 16% of the time. As the data demonstrate, it is not typical for imaging guidance to be billed with the procedure and this provides a cost savings to the Medicare program. In the past, payment policy has allowed imaging guidance to be billed separately when performed and NASS believes that this policy is appropriate and should be continued.

Additionally, NASS believes that there may be a need for increased provider education on this issue as anecdotal evidence shows that many physicians think that imaging guidance is included in code 62287 and therefore, are not billing it separately, as indicated by the Medicare data cited above.

Sincerely,

A handwritten signature in black ink that reads "WJ Sullivan". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

William Sullivan, MD
RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
*Originated from the Relativity Assessment Workgroup –
Different Specialty Performing from Survey, Codes Reported Together 75% or More, and High Volume Growth Screens*

February 2011

Electronic Analysis Implanted Pump

The Relativity Assessment Workgroup identified codes 62367, 62368, 95990 and 95991 as part of the Codes Reported Together 75% or More screen. In April 2010, the RUC recommended to refer these services to the CPT Editorial Panel to revise and describe those services with three separate codes. In October 2010, the CPT Editorial Panel created two new codes, 62369 and 62370, to report electronic analysis of programmable implanted pump for intrathecal or epidural drug infusion with reprogramming, with reprogramming and refill requiring and not requiring physician's skill and editorially revised three existing codes, 62367 to report without reprogramming or refill and codes 95990 and 95991, to report refilling and maintenance of implantable pump or reservoir for drug delivery requiring and not requiring physician skill.

62367 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill

The RUC reviewed the survey results of 34 pain medicine physicians, anesthesiologists and spine physicians for CPT code 62367 and agreed with the specialty societies that the current work RVU of 0.48 appropriately accounts for the physician work required to perform this service. Additionally, the RUC agreed with the specialty society that the pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes appropriately accounts for the work required to perform this service. The CPT Editorial Panel editorially revised this service to add “without refill” and the specialty societies indicated and the RUC agreed that this does not change the physician work required to perform this procedure. To further support the current work RVU of 0.48, the RUC compared 62367 to MPC codes 95900 *Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study* (work RVU = 0.42) and 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)* (work RVU = 0.50) and determined that the current value maintains the appropriate relativity among these similar services. **The RUC recommends maintaining the current work RVU of 0.48 for CPT code 62367.**

62369 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill

The RUC reviewed the survey results for CPT code 62369 and recommends that the survey 25th percentile work RVU of 0.67, as it appropriately accounts for the physician work required to perform this service. The RUC recommends pre-service time of 7 minutes, intra-service time of 15 minutes and post-service time of 5 minutes. The RUC determined that the pre-service is slightly higher for 62369 compared to 62367 to account for the physician ordering the solution to be injected into the pump/reservoir.

The RUC reviewed two reference services to support the 25th percentile work RVU of 0.67. CPT code 93294 *Interrogation device evaluation(s), up to 90 days* (work RVU= 0.65 and pre-time= 7.5 minutes, intra-time= 15 minutes and post time= 7.5 minutes) and code 99241 *Office consultation for a new or established patient* (work RVU= 0.64 and pre-time= 5 minutes, intra-time= 15 minutes and post time= 5 minutes) were reviewed and the RUC agreed that these services, with similar physician time, ensures the recommended value is relative across physician services. **The RUC recommends a work RVU of 0.67 for CPT code 62369.**

62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming*

Although CPT code 62368 was not surveyed, the RUC indicated and the specialty society agreed, that CPT code 62368 requires the exact same physician work and time as 62369, as the work involved in refilling the pump is done solely by clinical staff. Given that the physician work is identical between the two services, the RUC noted that the current work RVU of 0.75 for 62368 would create a rank order anomaly compared to 62369. Therefore, the RUC recommends to directly crosswalk the physician work RVUs, 0.67, and physician time of 7 minutes pre-time, 15 minutes intra-time and 5 minutes immediate post-time. **The RUC recommends a work RVU of 0.67 for CPT code 62368.**

62370 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)*

The RUC reviewed the survey results for CPT code 62370 and recommends crosswalking the physician work to 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU = 1.10 and total time = 35 minutes) as the 0.43 work difference compared to 62369 appropriately accounts for the physician skill required for this procedure ($1.10 - 0.67 = 0.43$). To further justify this value, the RUC referenced many services that have a work RVU of 1.10 and similar physician time that ensures the recommended value is relative across all physician services. These code references include CPT codes, 88360 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual* (work RVU = 1.10 and total time = 35 minutes) and 99379 *Physician supervision of a nursing facility patient* (work RVU = 1.10 and total time = 35 minutes). The RUC recommends pre-service time of 7 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. **The RUC recommends a work RVU of 1.10 for CPT code 62370.**

Work Neutrality

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

Practice Expense:

The RUC had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was refined with a comparison to the direct practice expenses of existing chemotherapy services.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲62367	G1	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill	XXX	0.48 (No Change)
62368	G4	with reprogramming (For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy, see 95990-95991)	XXX	0.67
●62369	G2	with reprogramming and refill	XXX	0.67
●62370	G3	with reprogramming and refill (requiring physician's skill) <u>(Do not report 62367-62370 in conjunction with 95990, 95991. For refilling and maintenance of a reservoir or an implantable infusion pump for spinal or brain drug delivery without reprogramming, see 95990, 95991)</u>	XXX	1.10
E 95990		Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), <u>includes electronic analysis of pump, when performed</u> (For analysis and/or reprogramming of implantable infusion pump, see 62367-62368 (For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy [eg, chemotherapy or insulin], use 96522)	XXX	0.00 (No Change)
E 95991		<u>administered by physician requiring physician's skill</u> <u>Do not report 95990-95991 in conjunction with 62367-62370. For analysis and/or reprogramming of implantable infusion pump, see 62367-62370)</u>	XXX	0.77 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>(For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy [eg, chemotherapy], use 96522)</u>		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
*Originated from the Relativity Assessment Workgroup –
Different Specialty Performing from Survey, Codes Reported Together 75% or More, and High Volume Growth Screens*

February 2011

Electronic Analysis Implanted Pump

The Relativity Assessment Workgroup identified codes 62367, 62368, 95990 and 95991 as part of the Codes Reported Together 75% or More screen. In April 2010, the RUC recommended to refer these services to the CPT Editorial Panel to revise and describe those services with three separate codes. In October 2010, the CPT Editorial Panel created two new codes, 62369 and 62370, to report electronic analysis of programmable implanted pump for intrathecal or epidural drug infusion with reprogramming, with reprogramming and refill requiring and not requiring physician's skill and editorially revised three existing codes, 62367 to report without reprogramming or refill and codes 95990 and 95991, to report refilling and maintenance of implantable pump or reservoir for drug delivery requiring and not requiring physician skill.

62367 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill

The RUC reviewed the survey results of 34 pain medicine physicians, anesthesiologists and spine physicians for CPT code 62367 and agreed with the specialty societies that the current work RVU of 0.48 appropriately accounts for the physician work required to perform this service. Additionally, the RUC agreed with the specialty society that the pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes appropriately accounts for the work required to perform this service. The CPT Editorial Panel editorially revised this service to add “without refill” and the specialty societies indicated and the RUC agreed that this does not change the physician work required to perform this procedure. To further support the current work RVU of 0.48, the RUC compared 62367 to MPC codes 95900 *Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study* (work RVU = 0.42) and 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)* (work RVU = 0.50) and determined that the current value maintains the appropriate relativity among these similar services. **The RUC recommends maintaining the current work RVU of 0.48 for CPT code 62367.**

62369 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill

The RUC reviewed the survey results for CPT code 62369 and recommends that the survey 25th percentile work RVU of 0.67, as it appropriately accounts for the physician work required to perform this service. The RUC recommends pre-service time of 7 minutes, intra-service time of 15 minutes and post-service time of 5 minutes. The RUC determined that the pre-service is slightly higher for 62369 compared to 62367 to account for the physician ordering the solution to be injected into the pump/reservoir.

The RUC reviewed two reference services to support the 25th percentile work RVU of 0.67. CPT code 93294 *Interrogation device evaluation(s), up to 90 days* (work RVU= 0.65 and pre-time= 7.5 minutes, intra-time= 15 minutes and post time= 7.5 minutes) and code 99241 *Office consultation for a new or established patient* (work RVU= 0.64 and pre-time= 5 minutes, intra-time= 15 minutes and post time= 5 minutes) were reviewed and the RUC agreed that these services, with similar physician time, ensures the recommended value is relative across physician services. **The RUC recommends a work RVU of 0.67 for CPT code 62369.**

62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming*

Although CPT code 62368 was not surveyed, the RUC indicated and the specialty society agreed, that CPT code 62368 requires the exact same physician work and time as 62369, as the work involved in refilling the pump is done solely by clinical staff. Given that the physician work is identical between the two services, the RUC noted that the current work RVU of 0.75 for 62368 would create a rank order anomaly compared to 62369. Therefore, the RUC recommends to directly crosswalk the physician work RVUs, 0.67, and physician time of 7 minutes pre-time, 15 minutes intra-time and 5 minutes immediate post-time. **The RUC recommends a work RVU of 0.67 for CPT code 62368.**

62370 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)*

The RUC reviewed the survey results for CPT code 62370 and recommends crosswalking the physician work to 56605 *Biopsy of vulva or perineum (separate procedure); 1 lesion* (work RVU = 1.10 and total time = 35 minutes) as the 0.43 work difference compared to 62369 appropriately accounts for the physician skill required for this procedure ($1.10 - 0.67 = 0.43$). To further justify this value, the RUC referenced many services that have a work RVU of 1.10 and similar physician time that ensures the recommended value is relative across all physician services. These code references include CPT codes, 88360 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual* (work RVU = 1.10 and total time = 35 minutes) and 99379 *Physician supervision of a nursing facility patient* (work RVU = 1.10 and total time = 35 minutes). The RUC recommends pre-service time of 7 minutes, intra-service time of 20 minutes and post-service time of 10 minutes. **The RUC recommends a work RVU of 1.10 for CPT code 62370.**

Work Neutrality

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

Practice Expense:

The RUC had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was refined with a comparison to the direct practice expenses of existing chemotherapy services.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲62367	G1	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming <u>or refill</u>	XXX	0.48 (No Change)
62368	G4	with reprogramming (For refilling and maintenance of an implantable infusion pump for spinal or brain drug therapy, see 95990-95991)	XXX	0.67
●62369	G2	with reprogramming and refill	XXX	0.67
●62370	G3	with reprogramming and refill (requiring physician's skill) <u>(Do not report 62367-62370 in conjunction with 95990, 95991. For refilling and maintenance of a reservoir or an implantable infusion pump for spinal or brain drug delivery without reprogramming, see 95990, 95991)</u>	XXX	1.10
E 95990		Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), <u>includes electronic analysis of pump, when performed</u> (For analysis and/or reprogramming of implantable infusion pump, see 62367-62368 (For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy [eg, chemotherapy or insulin], use 96522)	XXX	0.00 (No Change)
E 95991		<u>administered by physician requiring physician's skill</u> <u>Do not report 95990-95991 in conjunction with 62367-62370. For analysis and/or reprogramming of implantable infusion pump, see 62367-62370)</u>	XXX	0.77 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		<u>(For refill and maintenance of implanted infusion pump or reservoir for systemic drug therapy [eg, chemotherapy], use 96522)</u>		

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

CPT Code:62367 Tracking Number G1 Original Specialty Recommended RVU: **0.48**
 Presented Recommended RVU: **0.48**
 Global Period: XXX RUC Recommended RVU: **0.48**

CPT Descriptor: Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male presents for an electronic analysis of an implanted infusion pump that delivers opiates and has successfully controlled his pain due to prostate cancer and metastases to multiple bone sites in the lower body and resultant bilateral leg and pelvic bone pain (rated 8/10). Because of the multiple sites of bone involvement and lack of response to chemotherapy, no radiation therapy or further chemotherapy is planned. His expected survival time is 9 months from his cancer. The electronic analysis of the implanted pump device, which determines the rate of infusion and the amount of morphine solution remaining in the pump reservoir, indicates a satisfactory infusion rate and residual volume; so no reprogramming or refill is needed.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 3%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service includes: a review of patient medical chart with special attention to patient's response to drug delivery via implanted infusion pump

Description of Intra-Service Work: Electronic analysis is performed to determine reservoir status, alarm status, and the drug prescription status. Because the electronic analysis of the implanted pump device indicates a satisfactory infusion rate and residual volume; no reprogramming or refill is needed.

Description of Post-Service Work: Communication with the patient, family, and other health care professionals (including written and telephone reports and orders) on the day of the analysis are considered part of the post-operative work for this procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011				
Presenter(s):	Eduardo Fraifeld, MD, Fred Davis, MD, Joseph Zuhosky, MD, Marc Leib, MD, Christopher Merifield, MD, Bill Sullivan, MD, Charlie Mick, MD, David Carroway, MD, Chris DeWald, MD					
Specialty(s):	AAPM,AAPMR,ASA,ISIS,NASS,ASIPP					
CPT Code:	62367					
Sample Size:	720	Resp N:	34	Response: 4.7 %		
Sample Type:	Panel Additional Sample Information: Survey respondents represent a pool of physicians who responded to a website notice soliciting physicians willing to complete these surveys and also physicians who had completed previous surveys.					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.50	13.50	47.50	500.00
Survey RVW:		0.08	0.54	0.91	1.44	2.20
Pre-Service Evaluation Time:				6.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		2.00	5.00	10.00	15.00	25.00
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			
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); 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:	62367	Recommended Physician Work RVU: 0.48				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		10.00				
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			
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
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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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99213	XXX	0.97	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: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085
<u>CPT Descriptor 1</u> Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
92083	XXX	0.50	RUC Time	2,580,775

CPT Descriptor 2 Visual field examination, unilateral or bilateral,with interpretation and report; extended examination (eg Goldman visual fields with at least 3 isopters plotted and static determination within the central 30' 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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
69210	000	0.61	RUC Time

CPT Descriptor Removal impacted cerumen (separate procedure) 1 or both ears

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 8 % of respondents: 23.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 62367	<u>Key Reference CPT Code:</u> 99213	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	3.00	
Median Intra-Service Time	10.00	15.00	
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	20.00	23.00
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	3.13	3.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.38	3.38
Urgency of medical decision making	3.13	3.13

Technical Skill/Physical Effort (Mean)

Technical skill required	3.38	2.28
Physical effort required	3.13	2.75

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.75	3.25
Outcome depends on the skill and judgment of physician	3.75	3.50
Estimated risk of malpractice suit with poor outcome	3.75	3.00

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.13	2.88
Intra-Service intensity/complexity	3.38	3.38
Post-Service intensity/complexity	2.75	2.63

Additional Rationale and Comments

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 13,146 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. Per the RUC database the 2009 frequency was 13,146

Specialty Anesthesiology	Frequency 3858	Percentage 28.99 %
Specialty Interventional Pain	Frequency 2395	Percentage 18.00 %
Specialty Physical Medicine & Rehab	Frequency 2129	Percentage 16.00 %

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 62367

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:62369 Tracking Number G2 Original Specialty Recommended RVU: **0.75**
Presented Recommended RVU: **0.75**
Global Period: XXX RUC Recommended RVU: **0.67**

CPT Descriptor: Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (not requiring physician's skill)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65- year- old male has prostate cancer and metastases to multiple bone sites in the lower body and resultant bilateral leg and pelvic bone pain. A permanent implantable subcutaneous programmable infusion pump and an intrathecal infusion catheter were implanted for a long- term intrathecal infusion of narcotic. Because of inadequate pain control the patient now presents for refill and reprogramming of his pump, not requiring physician's skill

Percentage of Survey Respondents who found Vignette to be Typical: 82%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service includes a review of patient medical chart with special attention to patient's response to drug delivery via implanted infusion pump. The solution to be injected into the pump/reservoir is ordered by the physician

Description of Intra-Service Work: The nurse fills the pump under physician supervision and then electronic analysis is performed to determine reservoir status, alarm status, and the drug prescription status. Electronic analysis of the pump function verifies the infusion rate. Based on the patient's evaluation the pump is then reprogrammed to adjust the rate of infusion and control the increased level of pain. The pump alarm settings and reservoir levels are programmed as well as any changes made to the drug infusion concentration or mixture. Refill date estimates are also made.

Description of Post-Service Work: Communication with the patient, family, and other health care professionals (including written and telephone reports and orders) on the day of the analysis and reprogramming are considered part of the post-operative work for this procedure as well as a follow up phone call to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011				
Presenter(s):	Eduardo Fraifeld, MD, Fred Davis, MD, Joseph Zuhosky, MD, Marc Leib, MD, Christopher Merifield, MD, Bill Sullivan, MD, Charlie Mick, MD, David Carroway, MD, Chris DeWald, MD					
Specialty(s):	AAPM, ASA, AAPMR, ASIPP, ISIS, NASS					
CPT Code:	62369					
Sample Size:	723	Resp N:	28	Response: 3.8 %		
Sample Type:	Panel Additional Sample Information: Survey respondents represent a pool of physicians who responded to a website notice soliciting physicians willing to complete these surveys and also physicians who had completed previous surveys.					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	10.00	50.00	800.00
Survey RVW:		0.18	0.67	0.79	1.74	3.01
Pre-Service Evaluation Time:				5.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		0.00	5.00	15.00	20.00	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			
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); 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:	62369	Recommended Physician Work RVU: 0.75				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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			
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
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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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95991	XXX	0.77	RUC Time

CPT Descriptor REFILLING AND MAINTENANCE OF IMPLANTABLE PUMP OR RESERVOIR FOR DRUG DELIVERY, SPINAL (INTRATHECAL, EPIDURAL) OR BRAIN (INTRAVENTRICULAR); ADMINISTERED BY PHYSICIAN

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
20600	000	0.66	CMS Time File	389,742
<u>CPT Descriptor 1</u> Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
99202	XXX	0.93	RUC Time	2,352,028

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem-focused history, an expanded problem-focused examination; straightforward medical decision making. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the presenting problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of low or moderate severity.. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
20610	000	0.79	CMS Time File

CPT Descriptor Arthrocentesis, aspiration and/or injection; major joint or bursa (eg shoulder, hip, knee joint, subacromial bursa)

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 35.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 62369	<u>Key Reference CPT Code:</u> 95991	<u>Source of Time</u> RUC Time
Median Pre-Service Time	7.00	10.00	
Median Intra-Service Time	15.00	20.00	
Median Immediate Post-service Time	5.00	7.00	
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	37.00
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	3.10	3.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.10	3.20
Urgency of medical decision making	2.70	2.70

Technical Skill/Physical Effort (Mean)

Technical skill required	2.70	3.00
Physical effort required	2.30	2.60

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.40	3.40
Outcome depends on the skill and judgment of physician	3.00	3.30
Estimated risk of malpractice suit with poor outcome	3.70	3.60

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.70	2.80
Intra-Service intensity/complexity	2.80	3.10
Post-Service intensity/complexity	2.80	2.90

Additional Rationale and Comments

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 47,902 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate.

Specialty Anesthesiology	Frequency 12662	Percentage 21.99 %
Specialty Interventional Pain	Frequency 16116	Percentage 28.00 %
Specialty Pain Medicine	Frequency 5756	Percentage 10.00 %

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

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. 95991

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

CPT Code:62370 Tracking Number G3 Original Specialty Recommended RVU: **1.45**
Presented Recommended RVU: **1.45**
Global Period: XXX RUC Recommended RVU: **1.10**

CPT Descriptor: Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male has prostate cancer and metastases to multiple bone sites in the lower body and resultant bilateral leg and pelvic bone pain. A permanent implantable subcutaneous programmable infusion pump and an intrathecal infusion catheter were implanted for a long- term intrathecal infusion of narcotic. Because of inadequate pain control the patient now presents for refill (requiring physician's skill because of difficult access or other medical issues OR complex reprogramming of his pump)

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 7%

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? 7%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Pre-service includes a review of patient medical chart with special attention to patient's response to drug delivery via implanted infusion pump. The solution to be injected into the pump/reservoir is ordered by the physician.

Description of Intra-Service Work: Electronic analysis is performed to determine reservoir status, alarm status, drug prescription status. The subcutaneous pump is palpated and identified. The entire area over the pump is prepped and draped. Throughout all this procedure, sterile technique is meticulous to prevent infection. A pump refill kit is then opened and extra required supplies added to the kit

The solution's container is checked to be sure that the drug, the drug volume, and the drug's concentration are all correct according to what was ordered. Using sterile technique, the drug to be injected into the pump is then drawn from its transport vial into a sterile syringe using a filter needle.

The syringe is then connected to a Huber needle with an extension tube in the kit. The needle is advanced and probed to find the actual center of the pump reservoir and advanced through the injection septum of the pump into the reservoir to the proper depth. The residual volume of the solution is aspirated from the pump/reservoir and is measured and checked against the medical records and/or pump status printout to make sure the entire volume of the pump/reservoir has been

removed. The syringe containing the new solution attached to the tubing and then very slowly injected into the pump/reservoir. The patient is examined and pump/reservoir are then checked for any possible error in administration. The pump is then reprogrammed to adjust the rate of infusion and control the increased level of pain. The pump alarm settings and reservoir levels are programmed as well as any changes made to the drug infusion concentration or mixture. Refill date estimates are also made.

Description of Post-Service Work: Communication with the patient, family, and other health care professionals (including written and telephone reports and orders) on the day of the analysis and reprogramming are considered part of the post-operative work for this procedure as well as a follow up phone call to the patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011					
Presenter(s):	Eduardo Fraifeld, MD, Fred Davis, MD, Joseph Zuhosky, MD, Marc Leib, MD, Christopher Merifield, MD, Bill Sullivan, MD, Charlie Mick, MD, David Carroway, MD, Chris DeWald, MD					
Specialty(s):	AAPM, ASA, AAPMR, ASIPP, ISIS, NASS					
CPT Code:	62370					
Sample Size:	723	Resp N:	29	Response: 4.0 %		
Sample Type:	Panel Additional Sample Information: Survey respondents represent a pool of physicians who responded to a website notice soliciting physicians willing to complete these surveys and also physicians who had completed previous surveys.					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	15.00	50.00	500.00
Survey RVW:		0.75	0.80	1.45	2.25	3.55
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		5.00	15.00	20.00	25.00	45.00
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			
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); 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:	62370	Recommended Physician Work RVU: 1.45		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		20.00		
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 0.0	99239x 0.0	
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
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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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95991	XXX	0.77	RUC Time

CPT Descriptor REFILLING AND MAINTENANCE OF IMPLANTABLE PUMP OR RESERVOIR FOR DRUG DELIVERY, SPINAL (INTRATHECAL, EPIDURAL) OR BRAIN (INTRAVENTRICULAR); ADMINISTERED BY PHYSICIAN

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
99203	XXX	1.42	RUC Time	5,468,748

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history, a detailed examination; and decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the presenting problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
99214	XXX	1.50	RUC Time	72,747,651

CPT Descriptor 2 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 detailed history, a detailed examination; and decision making of moderate complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the presenting problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73219	XXX	1.62	RUC Time

CPT Descriptor Magnetic resonance (eg proton) imaging, upper extremity, other than joint; with contrast material(s)

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

Compare the pre-, intra-, and post-service time (by the median) and the 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:** 34.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 62370	<u>Key Reference CPT Code:</u> 95991	<u>Source of Time</u> RUC Time
Median Pre-Service Time	7.00	10.00	
Median Intra-Service Time	20.00	20.00	

Median Immediate Post-service Time	10.00	7.00
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	37.00	37.00
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	3.10	2.80
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.20	2.80
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Urgency of medical decision making	2.70	2.40
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.50	3.10
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Physical effort required	3.00	2.70
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.60	3.20
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Outcome depends on the skill and judgment of physician	3.60	3.30
--	------	------

Estimated risk of malpractice suit with poor outcome	3.70	3.30
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.00	2.60
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Intra-Service intensity/complexity	3.60	3.10
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Post-Service intensity/complexity	2.50	2.10
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
71,424 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate.

Specialty Anesthesiology	Frequency 31038	Percentage 37.99 %
Specialty Interventional Pain	Frequency 17153	Percentage 21.00 %
Specialty Pain Medicine	Frequency 11435	Percentage 13.99 %

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

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. 95991

	A	B	C	D	E	F	G	H	I	J	K
1	AMA/Specialty Society RVS Update Committee Recommendation			62367		62368		62369		62370	
2	Meeting Date: February 2011	CMS		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (not requiring physician's skill)	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)				
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD										
5	TOTAL CLINICAL LABOR TIME			29.0	0.0	36.0	0.0	75.0	0.0	71.0	0.0
6	RN/LPN/MTA	L037D									
7	RN	L051A									
8	TOTAL PRE-SERV CLINICAL LABOR TIME			6.0	0.0	6.0	0.0	12.0	0.0	12.0	0.0
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			20.0	0.0	27.0	0.0	66.0	0.0	56.0	0.0
10	RN/LPN/MTA	L037D		20.0		27.0		55.0		55.0	
11	RN	L051A						11.0		1.0	
12	TOTAL POST-SERV CLINICAL LABOR TIME	L037D		0.0	0.0	3.0	0.0	3.0	0.0	3.0	0.0
13	PRE-SERVICE										
14	Start: Following visit when decision for surgery or procedure made										
15	Complete pre-service diagnostic & referral forms	L037D		3		3		3		3	
16	Coordinate pre-surgery services	L037D		3		3		3		3	
17	Schedule space and equipment in facility										
18	Provide pre-service education/obtain consent										
19	Follow-up phone calls & prescriptions	L037D						3		3	
20	Other Clinical Activity (verify Rx X2, charting, review previous printout, proper storage (locked area) Schedule II drugs)	L037D						3		3	
21	End: When patient enters office/facility for surgery/procedure										
22	SERVICE PERIOD										
23	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure										
24	Interval history obtained by pain medicine nurse regarding course of treatment and pain related medical history	L037D		3		3		3		3	
25	Greet patient, provide gowning, ensure appropriate medical records are available	L037D		3		3		3		3	
26	Obtain vital signs	L037D		3		3		3		3	
27	Provide pre-service education/obtain consent	L037D						3		3	
28	Prepare room, equipment, supplies	L037D		2		2		2		2	
29	Setup scope (non facility setting only)										
30	Prepare and position patient	L037D						1		1	
31	Verify medication interaction, verify orders, second verification orders	L051A						0		0	
32	Assemble supplies	L037D						0		0	
33	Intra-service										
34	Assist physician in performing procedure										
35	RN/LPN/MTA	L037D		5		10		20		20	
36	RN	L051A						10			
37	Post-Service										
38	Monitor pt. following service	L037D						8		8	
39	Clean room/equipment by physician staff	L037D		3		3		3		3	

	A	B	C	D	E	F	G	H	I	J	K
1	AMA/Specialty Society RVS Update Committee Recommendation			62367		62368		62369		62370	
2	Meeting Date: February 2011	CMS		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (not requiring physician's skill)		Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
40	Complete medical record documentation , diagnostic forms, lab & X-ray requisitions, schedule II wasting	L037D		1		1		3		3	
41	Post procedure education /conditions for which patient should call office (side effects, complications) home care instructions /coordinate office visits /prescriptions	L037D				2		4		4	
42	End: Patient leaves office										
43	POST-SERVICE Period										
44	Start: Patient leaves office/facility										
45	Conduct phone calls/call in prescriptions	L037D				3		3		3	
46	End: with last office visit before end of global period										
47	MEDICAL SUPPLIES		Unit								
48	Minimun Supply Package for Vistis (Multi-specialty)			1		1		1		1	
49	Kit, refill for implantable medication pump	SA076						1		1	
50	Gloves, sterile	SB024						1		1	
51	Mask, surgical	SB033						1		1	
52	Syringe 20ml	SC053						2		2	
53	Povidone swabsticks (3 pack uou)	SJ043						1		1	
54	Bandage, strip 0.75in x 3in (Bandaid)	SG021						1		1	
55	Gauze, sterile 4in x 4in	SG055						1		1	
56	Needle, 18-27g	SC029						2		2	
57	Underpad 2ft x 3ft (Chux)	SB044						1		1	
58	EQUIPMENT										
59	Programmer, for implanted medication pump (spine), w-printer	EQ208		10		15		25		25	
60	Exam, power	EF031		10		15		25		25	
61											

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

CPT Long Descriptor:

62367 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill

62368 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming

62369 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (not requiring physician's skill)

62370 Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring physician's skill)

Global Period: XXX

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

Representatives from each of the associated Specialty Societies, including physicians who provide these services, met via conference call to discuss specific PE inputs. Existing inputs for existing codes 62367, 62368, 95990 and 95991 were reviewed as well as proposed changes developed for the October 2010 RUC meeting.

If you have provide 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:

- Review records and complete forms required for patient's chart
- For codes that include refill of pump, the nurse must handle the order for the patient specific and custom formulated narcotic mixture. The pharmacy must be contacted directly since there may be multiple Schedule II narcotics involved. A hard copy of the prescription must be sent to the pharmacy and follow-up fax and phone call of the prescription is required. Once the medication is received, the nursing personnel must confirm the correct formulation by comparing it to the prescription and previous printouts, record receiving the medication and assure safe storage (locked container) until the procedure. Since Schedule II narcotics are involved, two clinicians must verify and document that the received medication agrees with the original prescription and ensure secure and proper storage. When the medication has arrived the patient is contacted, instructions are reviewed and the pump refill is scheduled.

Intra-Service Clinical Labor Activities:

- Greet patient and obtain vital signs
- Advise patient on appropriate cautions and concerns and obtain consent
- Prepare room and equipment including warming of machine
- Obtain printout and compare to previous settings
- Assist with placement and operation of pump programmer to determine pump parameters such as reservoir status, alarm status, and drug prescription activities
- If reprogramming required, assist with reprogramming and evaluation and recording of new pump parameters
- For codes that include refill of pump, the patient must be positioned and the nurse assists to maintain patient position and proper exposure Patient is prepped and draped for sterile procedure.
- Since Schedule II narcotics are involved, a second staff member must verify the prescription verification obtained from storage prior to filling the pump
- Nurse facilitates sterile aspiration of medication into injection syringe(s). The access port is identified through the use of palpation and templates provided in the refill kit. Appropriate technique is used to ensure that medication is delivered into the pump reservoir
- Staff holds the transducer in position while physician reprograms the device. Two clinicians are always required during the actual performance of the refill.
- Since Schedule II narcotics are involved any wastage of medication needs to be witnessed and signed in the logbook
- The room is cleaned and the device must be cleaned antiseptically and stored.
- For codes with refill of pump, vital signs are obtained and patients are monitored for 15 minutes before leaving the office.
- Skin is cleansed and bandages placed.
- Patients are counseled regarding precautions

Post-Service Clinical Labor Activities:

- All patients are called the evening of the service to verify patient status and to evaluate patient's perception and evaluation of pump function.

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Identified through the Site of Service Anomaly Screen and Fourth Five-Year Review

April 2011

Destruction by Neurolytic Agent

CPT code 64626, *Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level* was identified by the RUC's Five-Year Review Identification Workgroup in April 2008 as potentially misvalued through the Site-of-Service Anomaly screen. In April 2010, the specialty society requested and the RUC agreed that 64622, 64623, 64626, 64627 be referred to CPT to clarify that imaging is required. In February 2011, the CPT Editorial Panel deleted four codes and created four new codes to describe neurolysis reported per joint (2 nerves per each joint) instead of per nerve under image guidance. This level of specificity allowed for the codes to better reflect current practice and the bundling of components. The panel also editorially revised codes 77003 and 77012 to no longer separately report fluoroscopic guidance and localization.

64633 *Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), single facet joint*

The RUC reviewed the specialty society's survey results of CPT code 61633X from 58 physicians who provide these services. An additional 4 minutes for proper prone positioning is important for these procedures, similar to other facet joint injection procedure positioning. The RUC compared the specialty recommended 25th percentile work RVU of 3.84 to the work of its key reference service 64681 *Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus* (work RVU = 3.78, intra time= 30 minutes). The RUC agreed that these two service have similar physician work with identical intra-service time, 30 minutes. The RUC concurred that the technical skill, stress, and intensity of 61633X is greater than that of 64681. The RUC agreed that the survey's 25th percentile work value is appropriate given the time, skill, and intensity required to perform this service. **The RUC recommends a work RVU of 3.84 for CPT code 61633X.**

64634 *Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), each additional facet joint (List separately in addition to code for primary procedure)*

The RUC discussed the specialty society's survey results of CPT code 61634X from 39 physicians who provide these types services. The RUC compared the specialty recommended 25th percentile work RVU of 1.32 to the work of its key reference service 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU = 1.16) and 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 1.44). The RUC concurred that the technical skill, stress, and intensity of add on code 61634X is greater than that of 64491 and less than 13122. The RUC agreed that the survey's 25th percentile work value was appropriate given the time, skill, and intensity of the service. **The RUC recommends a work RVU of 1.32 for CPT code 61634X.**

64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), single facet joint

The RUC discussed the specialty society's survey results of CPT code 61635X from 42 physicians who provide these types services. An additional 4 minutes for proper prone positioning is important for these procedures, similar to other facet joint injection procedure positioning. The RUC compared the specialty recommended 25th percentile work RVU of 3.78 to the work of its key reference service 64681 *Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus* (work RVU = 3.78, intra time = 30 minutes). The RUC agreed that these two services have similar physician work with identical intra-service times 30 minutes. The RUC concurred that the technical skill, stress, and intensity of 61635X can be equated to that of 64681. The RUC agreed that the specialty's 25th percentile survey work value was appropriate given the time, skill, and intensity of the service and noted that this service is less intense and complex in comparison to the cervical service 64633. **The RUC recommends a work RVU of 3.78 for CPT code 64635.**

64636 Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), each additional facet joint (List separately in addition to code for primary procedure)

The RUC discussed the specialty society's survey results of CPT code 61636 from 37 physicians who provide these types services. The RUC compared the specialty recommended 25th percentile work RVU of 1.16 to the work of its key reference service 64494 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)* (work RVU = 1.00, intra time= 15 minutes) and 13122 *Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)* (work RVU = 1.44). The RUC concurred that the technical skill, stress, and intensity of add on code 61636X is greater than that of 64494 and less than 13122. The RUC agreed that the survey's 25th percentile work value is appropriate given the time, skill, and intensity of the service. In addition, the RUC agreed that this add on service is less intense and complex than that of the cervical add-on service 64634. **The RUC recommends a work RVU of 1.16 for CPT code 61636.**

Practice Expense: The RUC reviewed the direct practice expense inputs for these new destruction by neurolytic agent services and reduced the clinical labor time recommended by the specialty to reflect the typical patient service for all four codes. The RUC made edits to the equipment recommended and agreed that the typical service was performed within a C-Arm room rather than a radiographic fluoroscopic room.

Work Neutrality

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

CPT Code (●New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Surgery Musculoskeletal System Spine (Vertebral Column)</p> <p><i><u>(Do not append modifier 62 to bone graft code 20931)</u></i></p> <p><i><u>(For injection procedure for myelography, use 62284)</u></i></p> <p><i><u>(For injection procedure for discography, see 62290, 62291)</u></i></p> <p><i><u>(For injection procedure, chemonucleolysis, single or multiple levels, use 62292)</u></i></p> <p><i><u>(For injection procedure for facet joints, see 64490-64495, 64622-64627, 64633-64636)</u></i></p> <p><i><u>(For needle or trocar biopsy, see 20220-20225)</u></i></p>				
<p>Nervous System Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency)</p> <p>Codes 64600-64681 include the injection of other therapeutic agents (eg, corticosteroids). <u>Do not report diagnostic/therapeutic injections separately.</u> (For therapies that are not destructive of the target nerve [eg, pulsed radiofrequency]), use 64999)</p> <p>Somatic nerves</p>				
E 64620		<p>Destruction by neurolytic agent, intercostal nerve</p> <p>(For fluoroscopic guidance and localization for needle placement and neurolysis in conjunction with 64622-64627, use 77003)</p> <p><u>(Imaging guidance [fluoroscopy CT] are inclusive components of 64633-64636)</u></p>	010	2.89 (No Change)
D 64622		Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or	010	N/A

CPT Code (●New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
		sacral, single level (For bilateral procedure, report 64622 with modifier 50)		
D +64623		lumbar or sacral, each additional level (List separately in addition to code for primary procedure) (Use 64623 in conjunction with 64622) (For bilateral procedure, report 64623 with modifier 50)	ZZZ	N/A
D 64626		cervical or thoracic, single level (For bilateral procedure, report 64626 with modifier 50)	010	N/A
D +64627		cervical or thoracic, each additional level (List separately in addition to code for primary procedure) (Use 64627 in conjunction with 64626) (For bilateral procedure, report 64627 with modifier 50) <u>(64622-64627 have been deleted. For image guided neurolysis of facet joint nerve(s), see 64633-64636)</u> <u>(Imaging guidance [fluoroscopy, CT] are inclusive components of 64633-64636)</u> <u>(Image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64633-64636. Image guidance and localization are required for the performance of paravertebral facet joint nerve destruction by neurolytic agent described by 64633-64636. If CT or fluoroscopic imaging is not used, report 64999)</u> (For paravertebral facet destruction by neurolysis of the T12-L1 joint, or	ZZZ	N/A

CPT Code (●New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
		nerves innervating that joint, use 64634)		
#●64633	Y1	Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), single facet joint (For bilateral procedure, report 64633 with modifier 50)	010	3.84
#+●64634	Y2	cervical or thoracic, with image guidance (fluoroscopy or CT), each additional facet joint (List separately in addition to code for primary procedure) (Use 64634 in conjunction with 64633) (For bilateral procedure, report 64634 with modifier 50)	ZZZ	1.32
#●64635	Y3	lumbar or sacral, with image guidance (fluoroscopy or CT), single facet joint (For bilateral procedure, report 64635 with modifier 50)	010	3.78
#+●64636	Y4	lumbar or sacral, with image guidance (fluoroscopy or CT), each additional facet joint (List separately in addition to code for primary procedure) (Use 64636 in conjunction with 64635) (For bilateral procedure, report 64636 with modifier 50) (Do not report 64633-64636 in conjunction with 77003, 77012)	ZZZ	1.16
Radiology Radiologic Guidance Fluoroscopic Guidance				

CPT Code (●New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
E 77003		<p>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</p> <p>(For paravertebral facet joint injection, see 64490-64495. For paravertebral facet joint nerve destruction by neurolysis, see 64633-64636. For transforaminal epidural needle placement and injection, see 64479-64484)</p> <p>(Do not report 77003 in conjunction with 64479-64484, 64490-64495, <u>64633-64636</u>)</p> <p>(For destruction by neurolytic agent, see 64600-64680)</p> <p>(For percutaneous or endoscopic lysis of epidural adhesions, 62263, 62264 include fluoroscopic guidance and localization)</p>	XXX	0.60 (No Change)
Computed Tomography Guidance				
E 77012		<p>Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation</p> <p>(Do not report 77012 in conjunction with 64479-64484, 64490-64495, <u>64633-64636</u>, 0232T)</p>	XXX	1.16 (No Change)

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

CPT Code: 64633 Tracking Number Y1

Original Specialty Recommended RVU: **4.44**Presented Recommended RVU: **3.84**

Global Period: 010

RUC Recommended RVU: **3.84**

CPT Descriptor: Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), single facet joint

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female involved in a flexion extension injury from an automobile accident presents with constant neck pain. The patient's history includes imaging studies with findings of minimal degenerative disc disease and cervical spondylosis. The patient had no relief with conservative treatments such as, physical therapy, NSAIDs, or trigger point injections. Previous trials of cervical medial branch blocks provided significant short-term relief. She undergoes radiofrequency neurotomy of the two medial branch nerves innervating the symptomatic facet joint.

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 24% , In the ASC 41%, In the office 34%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Kept overnight (less than 24 hours) 0% , Admitted (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? 74%

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? 51%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review of records and any pertinent imaging studies
- Confirm results of the diagnostic facet injections with patient
- Communicating with other professionals, patient, and family; and obtaining consent.
- Dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure.
- Positioning the patient on the x-ray table for appropriate fluoroscopic view, and draping of the injection site.

Description of Intra-Service Work:

- The patient is monitored with continuous pulse oximetry, blood pressure and ECG.
- A C-arm fluoroscopy machine is rotated and adjusted until the targeted facet joint and the bony landmarks are optimally visualized.
- The skin and subcutaneous tissues are anesthetized with local anesthetic.
- A needle is directed towards the lateral facet pillar and groove under intermittent fluoroscopic guidance. Care must be taken to avoid vital neural structures or blood vessels.
- The patient is stimulated with appropriate frequencies for sensory and motor stimulation to verify that the needle is in the correct position

- Appropriate positioning of the needle tip is confirmed with multiple fluoroscopic views, including A-P and lateral projections.
- Anesthetic is injected.
- Radiofrequency ablation of the nerve is performed.
- The probe is re-positioned, to complete additional lesion(s) along the nerve.
- The entire procedure is repeated for the second medial branch nerve.
- After both nerves are lesioned, a dressing is applied.

Description of Post-Service Work:

- After the procedure, the patient is observed for any new and unexpected neurological deficits.
- The physician reviews the procedure and results with the patient and other professionals (including written and telephone reports and orders).
- Office visit within the 10 days global to monitor for complications, assessment of pain/pain relief and documentation of functional outcome are included in post-service work.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Christopher Merifield, MD; Marc Leib, MD; Eduardo Fraifeld, MD; William Sullivan, MD; David Caraway, MD; Scott Horn, DO				
Specialty(s):	American Society of Anesthesiologists (ASA); International Spine Intervention Society (ISIS); American Academy of Pain Medicine (AAPM); American Society of Interventional Pain Physicians (ASIPP); American Academy of Physical Medicine and Rehabilitation (AAMPR); North American Spine Society (NASS)				
CPT Code:	64633				
Sample Size:	922	Resp N:	58	Response: 6.2 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	5.00	50.00	100.00
Survey RVW:		1.65	3.84	4.44	5.14
Pre-Service Evaluation Time:				30.00	
Pre-Service Positioning Time:				9.00	
Pre-Service Scrub, Dress, Wait Time:				5.00	
Intra-Service Time:		10.00	16.00	30.00	37.00
Immediate Post Service-Time:		15.00			
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:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:

2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	64633	Recommended Physician Work RVU: 3.84		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		18.00	18.00	0.00
Pre-Service Positioning Time:		5.00	1.00	4.00
Pre-Service Scrub, Dress, Wait Time:		6.00	6.00	0.00
Intra-Service Time:		30.00		
Immediate Post Service-Time:		15.00		
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
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
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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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64681	010	3.78	RUC Time

CPT Descriptor Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
65855	010	3.99	RUC Time	157,539

CPT Descriptor 1 Trabeculoplasty by laser surgery, 1 or more sessions (defined treatment series)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
20103	010	5.34	RUC Time	1,514

CPT Descriptor 2 Exploration of penetrating wound (separate procedure); extremity

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62264	010	4.42	RUC Time

CPT Descriptor Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 18 **% of respondents:** 31.0 %

TIME ESTIMATES (Median)

	CPT Code: 64633	Key Reference CPT Code: 64681	Source of Time RUC Time
Median Pre-Service Time	29.00	32.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	15.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	40.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	23.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	116.00	122.00
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	3.44	3.71
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.71
Urgency of medical decision making	2.56	3.12

Technical Skill/Physical Effort (Mean)

Technical skill required	4.28	4.00
Physical effort required	3.28	3.18

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.67	3.88
Outcome depends on the skill and judgment of physician	4.17	4.12
Estimated risk of malpractice suit with poor outcome	3.78	3.65

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.11	2.88
Intra-Service intensity/complexity	3.89	3.82
Post-Service intensity/complexity	2.72	2.76

Additional Rationale and Comments

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

The specialty believes that the survey results may actually underestimate the time and values. Specialty members are used to the current coding structure, and it is not clear how well they remember the exact

Specialty Interventional Pain Management	Frequency 11000	Percentage 37.93 %
Specialty Anesthesiology	Frequency 9000	Percentage 31.03 %
Specialty Pain Management	Frequency 3000	Percentage 10.34 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 14,500 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. About half of the utilization for 64626, as the code will now be reported per joint

Specialty Intervential Pain Management	Frequency 5500	Percentage 37.93 %
Specialty Anesteshology	Frequency 4500	Percentage 31.03 %
Specialty Physical Management	Frequency 1450	Percentage 10.00 %

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

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. 64626

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

CPT Code:64634 Tracking Number Y2

Original Specialty Recommended RVU: **2.12**Presented Recommended RVU: **1.32**

Global Period: ZZZ

RUC Recommended RVU: **1.32**

CPT Descriptor: Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), each additional facet joint

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female involved in a flexion extension injury from an automobile accident presents with constant neck pain. The patient's history includes imaging studies with findings of minimal degenerative disease and cervical spondylosis. The patient received no relief with conservative treatments such as, physical therapy, NSAIDs, or trigger point injections. Previous trials of cervical medial branch blocks provided significant short-term relief. She undergoes radiofrequency neurotomy two medial branch nerves innervating the additional symptomatic facet joint.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 68%

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? 59%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work:

- The patient is monitored with continuous pulse oximetry, blood pressure and ECG.
- A C-arm fluoroscopy machine is rotated and adjusted until the targeted facet joint and the bony landmarks are optimally visualized.
- The skin and subcutaneous tissues are anesthetized with local anesthetic.
- A needle is directed towards the lateral facet pillar and groove under intermittent fluoroscopic guidance. Care must be taken to avoid vital neural structures or blood vessels.
- The patient is stimulated with appropriate frequencies for sensory and motor stimulation to verify that the needle is in the correct position
- Appropriate positioning of the needle tip is confirmed with multiple fluoroscopic views, including A-P and lateral projections.
- Anesthetic is injected.
- Radiofrequency ablation of the nerve is performed.
- The probe is re-positioned, to complete additional lesion(s) along the nerve.

- The entire procedure is repeated for the second medial branch nerve.
- After both nerves are lesioned, a dressing is applied.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Christopher Merifield, MD; Marc Leib, MD; Eduardo Fraifeld, MD; William Sullivan, MD; Joseph Zuhosky, MD; David Caraway, MD; Scott Horn, DO				
Specialty(s):	American Society of Anesthesiologists (ASA); International Spine Intervention Society (ISIS); American Academy of Pain Medicine (AAPM); American Society of Interventional Pain Physicians (ASIPP); American Academy of Physical Medicine and Rehabilitation (AAMPR); North American Spine Society (NASS)				
CPT Code:	64634				
Sample Size:	922	Resp N:	39	Response:	4.2 %
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	2.00	45.00	75.00
Survey RVW:		1.16	1.32	2.12	4.00
Pre-Service Evaluation Time:				10.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		7.00	15.00	20.00	30.00
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:

ZZZ Global Code

CPT Code:	64634	Recommended Physician Work RVU: 1.32		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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
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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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64491	ZZZ	1.16	RUC Time

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
13122	ZZZ	1.44	RUC Time	14,878

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
22525	ZZZ	4.47	RUC Time	13,121

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22522	ZZZ	4.30	RUC Time

CPT Descriptor Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (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: 19 % of respondents: 48.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 64634	<u>Key Reference CPT Code:</u> 64491	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	15.00	
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	20.00	15.00
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	3.26	3.05
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.26	3.00
Urgency of medical decision making	2.32	2.16

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.37
Physical effort required	2.89	2.68

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.42	2.79
Outcome depends on the skill and judgment of physician	4.00	3.32
Estimated risk of malpractice suit with poor outcome	3.47	2.95

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.65	2.41
Intra-Service intensity/complexity	3.79	3.16
Post-Service intensity/complexity	2.65	2.29

Additional Rationale and Comments

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

Code 64626 was identified by CMS during 5 year review as a code with a site-of-service anomaly. The specialty societies chose not to survey immediately, or to use reverse building block methodology, but instead proposed that the entire family (64622-64627) be reviewed by the CPT Editorial Panel to revise the code descriptors to better reflect current practice and bundle components together.

The specialty believes that the survey results may actually underestimate the time and values. Specialty members are used to the current coding structure, and it is not clear how well they remember the exact language of the current CPT descriptor and if they paid enough attention when taking the survey to fully appreciate the slight revisions in the language.

Intra-service time must account for needle positioning, sensory stimulation and ablation time, which is performed more than once for each of the two nerves in a joint. Therefore, we recommend 30 minutes for the intra-service time. We also recommend to keep the time consistent for each one of the codes in this family - both, the base codes and the add-on codes, as has been the case with facet joint injections.

The reference code most commonly chosen for both of the base codes – 64681 at 3.78 RVUs (with 32 minutes pre and 20 minutes immediate post service time) validates the proposed pre and post service times for the base codes; as well as the intra-service time all the codes in this family, as it includes 30 minutes intra-service time and involves lesioning of only one nerve, and does not require fluoroscopic guidance.

The second most commonly chosen reference service for both base codes was 64464, which includes 30 minutes of intra-service time (40 pre and 20 post) has a value of 4.42 RVUs.

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. This code will be billed with the base code 64633X

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64627 x 2; 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 Pain Management	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 64000
 If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. About twice as many the Medicare frequency, which is estimated at about half of previous utilization of 64627 - now the code will be billed per joint (2 nerves) instead of per nerve

Specialty Interventional Pain Management	Frequency 25000	Percentage 39.06 %
Specialty Anesthesiology	Frequency 20000	Percentage 31.25 %
Specialty Pain Management	Frequency 6000	Percentage 9.37 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 32,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. About half of previous utilization of 64627 - now the code will be billed per joint (2 nerves) instead of per nerve

Specialty Interventional Pain Management	Frequency 13000	Percentage 40.62 %
Specialty Anesthesiology	Frequency 10000	Percentage 31.25 %
Specialty Pain Management	Frequency 3000	Percentage 9.37 %

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

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. 64627

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

CPT Code:64635 Tracking Number Y3

Original Specialty Recommended RVU: **4.24**Presented Recommended RVU: **3.78**

Global Period: 010

RUC Recommended RVU: **3.78**

CPT Descriptor: Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), single facet joint

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female involved in a flexion-extension injury from an automobile accident, presents with constant low back pain. The patient's history includes imaging studies with findings of minimal degenerative disc disease and no facet arthropathy. The patient had no relief with conservative treatments such as physical therapy, NSAIDs, or trigger point injections. Previous trials of lumbar medial branch blocks provided significant short-term relief of her low back pain. She undergoes radiofrequency neurotomy of the two medial branch nerves innervating the symptomatic facet joint.

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 31% , In the ASC 38%, In the office 31%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Kept overnight (less than 24 hours) 0% , Admitted (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? 66%

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? 44%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review of records and any pertinent imaging studies
- Reconfirm results of the diagnostic facet injections with patient
- Communicating with other professionals, patient, and family; and obtaining consent.
- Dressing, scrubbing, and waiting before the procedure, preparing the patient and needed equipment for the procedure.
- Positioning the patient on the x-ray table for appropriate fluoroscopic view, and draping of the injection site

Description of Intra-Service Work:

- The patient is monitored with continuous pulse oximetry, blood pressure and ECG.
- A C-arm fluoroscopy machine is rotated and adjusted until the targeted facet joint and the bony landmarks are optimally visualized.
- The skin and subcutaneous tissues are anesthetized with local anesthetic.
- A needle is directed towards the lateral facet pillar and groove under intermittent fluoroscopic guidance. Care must be taken to avoid vital neural structures or blood vessels.

- The patient is stimulated with appropriate frequencies for sensory and motor stimulation to verify that the needle is in the correct position
- Appropriate positioning of the needle tip is confirmed with multiple fluoroscopic views, including A-P and lateral projections.
- Anesthetic is injected.
- Radiofrequency ablation of the nerve is performed.
- The probe is re-positioned, to complete additional lesion(s) along the nerve.
- The entire procedure is repeated for the second medial branch nerve.
- After both nerves are lesioned, a dressing is applied.

Description of Post-Service Work:

- After the procedure, the patient is observed for any new and unexpected neurological deficits.
- The physician reviews the procedure and results with the patient and other professionals (including written and telephone reports and orders).
- Office visit within the 10 days global to monitor for complications, assessment of pain/pain relief and documentation of functional outcome are included in post-service work.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Christopher Merifield, MD; Marc Leib, MD; Eduardo Fraifeld, MD; William Sullivan, MD; David Caraway, MD; Scott Horn, DO				
Specialty(s):	American Society of Anesthesiologists (ASA); International Spine Intervention Society (ISIS); American Academy of Pain Medicine (AAPM); American Society of Interventional Pain Physicians (ASIPP); American Academy of Physical Medicine and Rehabilitation (AAMPR); North American Spine Society (NASS)				
CPT Code:	64635				
Sample Size:	922	Resp N:	42	Response: 4.5 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	8.00	60.00	100.00
Survey RVW:		1.55	3.78	4.24	4.58
Pre-Service Evaluation Time:				30.00	
Pre-Service Positioning Time:				5.00	
Pre-Service Scrub, Dress, Wait Time:				5.00	
Intra-Service Time:		10.00	20.00	28.00	34.00
Immediate Post Service-Time:		15.00			
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:	38.00	99238x 1.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	23.00	99211x 0.00	12x 0.00	13x 1.00	14x 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:

2a-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	64635	Recommended Physician Work RVU: 3.78		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		18.00	18.00	0.00
Pre-Service Positioning Time:		5.00	1.00	4.00
Pre-Service Scrub, Dress, Wait Time:		6.00	6.00	0.00
Intra-Service Time:		30.00		
Immediate Post Service-Time:	15.00			
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):	23.00	99211x 0.00	12x 0.00	13x 1.00
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
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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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64681	010	3.78	RUC Time

CPT Descriptor Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
65855	010	3.99	RUC Time	157,539

CPT Descriptor 1 Trabeculectomy by laser surgery, 1 or more sessions (defined treatment series)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
20103	010	5.34	RUC Time	1,514

CPT Descriptor 2 Exploration of penetrating wound (separate procedure); extremity

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
62264	010	4.42	RUC Time

CPT Descriptor Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 18 **% of respondents:** 42.8 %

TIME ESTIMATES (Median)

	CPT Code: 64635	Key Reference CPT Code: 64681	Source of Time RUC Time
Median Pre-Service Time	29.00	32.00	
Median Intra-Service Time	30.00	30.00	
Median Immediate Post-service Time	15.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	40.00	
Median Discharge Day Management Time	19.0	0.00	
Median Office Visit Time	23.0	0.00	
Prolonged Services Time	0.0	0.00	

Median Subsequent Observation Care Time	0.0	0.00
Median Total Time	116.00	122.00
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	3.22	3.22
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.11	2.94
Urgency of medical decision making	2.17	2.82

Technical Skill/Physical Effort (Mean)

Technical skill required	3.61	3.67
Physical effort required	3.06	3.00

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.17	3.67
Outcome depends on the skill and judgment of physician	4.06	3.83
Estimated risk of malpractice suit with poor outcome	3.11	3.50

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.89	3.06
Intra-Service intensity/complexity	3.44	3.50
Post-Service intensity/complexity	2.94	2.94

Additional Rationale and Comments

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

Code 64626 was identified by CMS during 5 year review as a code with a site-of-service anomaly. The specialty societies chose not to survey immediately, or to use reverse building block methodology, but instead

proposed that the entire family (64622-64627) be reviewed by the CPT Editorial Panel to revise the code descriptors to better reflect current practice and bundle components together.

As a result of the CPT revision, the code will now be reported per joint (2 nerves per each joint) instead of per nerve, as has been the case. Imaging has also been included and cannot be reported separately.

The society believes that the survey results may actually underestimate the time and values. Its members are used to the current coding structure, and it is not clear how well they remember the exact language of the current CPT descriptor and if they paid enough attention when taking the survey to fully appreciate the slight revisions in the language.

Intra-service time must account for needle positioning, sensory stimulation and ablation time, which is performed more than once for each of the two nerves in a joint. Therefore, we recommend 30 minutes for the intra-service time. We also recommend to keep the time consistent for each one of the codes in this family - both, the base codes and the add-on codes, as has been the case with facet joint injections.

The reference code most commonly chosen for both of the base codes – 64681 at 3.78 RVUs (with 32 minutes pre and 20 minutes immediate post service time) validates the proposed pre and post service times for the base codes; as well as the intra-service time all the codes in this family, as it includes 30 minutes intra-service time and involves lesioning of only one nerve, and does not require fluoroscopic guidance.

The second most commonly chosen reference service for both base codes was 64464, which includes 30 minutes of intra-service time (40 pre and 20 post) has a value of 4.42 RVUs.

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. This code may be reported with an add-on code 64636X

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64622 x2, 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.

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

CPT Code:64636 Tracking Number Y4

Original Specialty Recommended RVU: **1.72**Presented Recommended RVU: **1.16**

Global Period: ZZZ

RUC Recommended RVU: **1.16**

CPT Descriptor: Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), each additional facet joint

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old female involved in a flexion extension injury from an automobile accident presents with constant low back pain. The patient's history includes imaging studies with findings of minimal degenerative disc disease and no facet arthropathy. The patient had no relief with conservative treatments such as, physical therapy, NSAIDs, or trigger point injections. Previous trials of lumbar medial branch blocks provided significant short-term relief. She undergoes radiofrequency neurotomy of the two medial branch nerves innervating the additional symptomatic facet joint.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 68%

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? 44%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work:

- The patient is monitored with continuous pulse oximetry, blood pressure and ECG.
- A C-arm fluoroscopy machine is rotated and adjusted until the targeted facet joint and the bony landmarks are optimally visualized.
- The skin and subcutaneous tissues are anesthetized with local anesthetic.
- A needle is directed towards the lateral facet pillar and groove under intermittent fluoroscopic guidance. Care must be taken to avoid vital neural structures or blood vessels.
- The patient is stimulated with appropriate frequencies for sensory and motor stimulation to verify that the needle is in the correct position
- Appropriate positioning of the needle tip is confirmed with multiple fluoroscopic views, including A-P and lateral projections.
- Anesthetic is injected.
- Radiofrequency ablation of the nerve is performed.

- The probe is re-positioned, to complete additional lesion(s) along the nerve.
- The entire procedure is repeated for the second medial branch nerve.
- After both nerves are lesioned, a dressing is applied.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Christopher Merifield, MD; Marc Leib, MD; Eduardo Fraifeld, MD; William Sullivan, MD; David Caraway, MD; Scott Horn, DO					
Specialty(s):	American Society of Anesthesiologists (ASA); International Spine Intervention Society (ISIS); American Academy of Pain Medicine (AAPM); American Society of Interventional Pain Physicians (ASIPP); American Academy of Physical Medicine and Rehabilitation (AAMPR); North American Spine Society (NASS)					
CPT Code:	64636					
Sample Size:	922	Resp N:	37	Response: 4.0 %		
Sample Type:	Panel	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	7.00	80.00	100.00	2300.00
Survey RVW:		1.00	1.16	1.72	3.00	7.00
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		5.00	10.00	15.00	30.00	60.00
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:

ZZZ Global Code

CPT Code:	64636	Recommended Physician Work RVU: 1.16			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
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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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
64494	<u>ZZZ</u>	1.00	<u>RUC Time</u>

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
13122	<u>ZZZ</u>	1.44	<u>RUC Time</u>	14,878

CPT Descriptor 1 Repair, complex, scalp, arms, and/or legs; each additional 5 cm or less (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
22525	<u>ZZZ</u>	4.47	<u>RUC Time</u>	13,121

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
22522	<u>ZZZ</u>	4.30	<u>RUC Time</u>

CPT Descriptor Percutaneous vertebroplasty, 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (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: 20 % of respondents: 54.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 64636	<u>Key Reference CPT Code:</u> 64494	<u>Source of Time</u>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	15.00	
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	20.00	15.00
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	3.10	2.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.15	2.95
Urgency of medical decision making	2.35	2.15

Technical Skill/Physical Effort (Mean)

Technical skill required	3.65	3.25
Physical effort required	2.85	2.65

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.20	2.80
Outcome depends on the skill and judgment of physician	3.80	3.25
Estimated risk of malpractice suit with poor outcome	3.25	2.80

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.85	2.50
Intra-Service intensity/complexity	3.55	2.90
Post-Service intensity/complexity	2.65	2.25

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

Code 64626 was identified by CMS during 5 year review as a code with a site-of-service anomaly. The specialty societies chose not to survey immediately, or to use reverse building block methodology, but instead proposed that the entire family (64622-64627) be reviewed by the CPT Editorial Panel to revise the code descriptors to better reflect current practice and bundle components together.

As a result of the CPT revision, the code will now be reported per joint (2 nerves per each joint) instead of per nerve, as has been the case. Imaging has also been included and cannot be reported separately.

The society's believes that the survey results may actually underestimate the time and values. Its members are used to the current coding structure, and it is not clear how well they remember the exact language of the current CPT descriptor and if they paid enough attention when taking the survey to fully appreciate the slight revisions in the language.

Intra-service time must account for needle positioning, sensory stimulation and ablation time, which is performed more than once for each of the two nerves in a joint. Therefore, we recommend 30 minutes for the intra-service time. We also recommend to keep the time consistent for each one of the codes in this family - both, the base codes and the add-on codes, as has been the case with facet joint injections.

The reference code most commonly chosen for both of the base codes – 64681 at 3.78 RVUs (with 32 minutes pre and 20 minutes immediate post service time) validates the proposed pre and post service times for the base codes; as well as the intra-service time all the codes in this family, as it includes 30 minutes intra-service time and involves lesioning of only one nerve, and does not require fluoroscopic guidance.

The second most commonly chosen reference service for both base codes was 64464, which includes 30 minutes of intra-service time (40 pre and 20 post) has a value of 4.42 RVUs.

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. This is an add-on code and will be used with 64635X

FREQUENCY INFORMATION

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

CPT Long Descriptor:

64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), single facet joint

64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), single facet joint

Global Period: 010

Meeting Date: April 2011

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 of all involved specialty societies was convened to review the Practice Expense inputs for codes 64633-64636. The panel included physicians practicing in a wide variety of settings and geographic locations.

The panel reviewed the procedures and concluded that for the procedures performed in a facility setting, it was most appropriate to crosswalk the clinical staff inputs from the recently approved transforaminal epidural injection codes (64479-64484) and facet joint injection codes (64490-64495). Both of these code families are spinal/paraspinal procedures performed under fluoroscopic guidance, which have been recently reviewed by the PE Subcommittee and assigned nearly identical clinical staff times.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Complete pre-service diagnostic and referral forms.
- Call the hospital to schedule space and equipment needed in the facility and coordinate with the facility, the patient and other offices as necessary to prepare for the procedure.
- Provide and review educational materials and information prior to the procedure.
- Call in any prescriptions necessary for the patient prior to the procedure
- Contact the patient prior to the procedure to confirm pre-procedure instructions are being carried out.
- Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- Conduct phone calls/call-in prescriptions

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

CPT Long Descriptor:

- 64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), single facet joint
- 64634 Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), each additional facet joint
- 64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), single facet joint
- 64636 Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), each additional joint

Global Period: 010 (64633 and 64635); ZZZ (64633 and 64636)

Meeting Date: April 2011

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 of all involved specialty societies was convened to review the Practice Expense inputs for codes 64633X-64636X. The panel included physicians practicing in a wide variety of settings and geographic locations.

The panel reviewed the procedures and concluded that it was most appropriate to crosswalk most of the clinical staff inputs from the recently approved transforaminal epidural injection codes (64479-64484) and facet joint injection codes (64490-64495). Both of these code families are spinal/paraspinal procedures performed under fluoroscopic guidance, and have been recently reviewed by the PE Subcommittee.

For the two procedures with 010 global period, additional standard packages for clinical staff times were added for instrument cleaning, discharge activities, and a follow up office visit.

Please describe in detail the clinical activities of your staff:

010 GLOBAL:

Pre-Service Clinical Labor Activities:

- The clinical staff completes pre-service diagnostic and referral forms.
- Schedule space and equipment needed.
- Provide and review educational materials and information prior to the procedure.
- Call in any prescriptions necessary for the patient prior to the procedure
- Contact the patient prior to the procedure to confirm pre-procedure instructions are being

AMA Specialty Society RVS Update Committee Recommendation

carried out.

- Calls may also be necessary to coordinate changes in polypharmacy prior to the procedure.

RT:

- The RT obtains and displays the previous images.

Intra-Service Clinical Labor Activities:

- Clinical staff reviews the chart to be certain all pre-procedure testing is available and the medical history is current.
- Greet and gown the patient
- Obtain four vital signs.
- Review the procedure with the patient.
- Prepare the room, making certain supplies and equipment necessary are available.
- Assists the physician with prepping, positioning, and providing anesthesia.
- Remain in the room and assist the physician with the entire procedure.
- After completion of the procedure, monitor the patient.
- Clean the room; check dressings; and provide instructions on pain control and follow-up visits.

RT:

- Prepare the imaging equipment and input patient and procedure information.
- Position the C-arm and assist in final positioning of the patient and obtain scout films.
- Perform imaging as required during the procedure.
- At the end of the procedure, clean the equipment and process and store hard copies of films.

Post-Service Clinical Labor Activities:

- Phone calls/prescription calls

ZZZ GLOBAL

- The clinical staff remains in the room and assists the physician while the additional joint level is denervated.
- The RT remains in the room and performs imaging as required while the additional joint level is denervated.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	AMA/Specialty Society RVS Update Committee Recommendation			64633			64634			64635			64636		
2	Meeting Date: April 2011			Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), single facet joint			Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), each additional facet joint			Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), single facet joint			Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), each additional facet joint		
		CMS													
3	LOCATION	Code		Non Facility	Non Facility	Facility	Non Facility	Non Facility	Facility	Non Facility	Non Facility	Facility	Non Facility	Non Facility	Facility
4				RT LO41B	RN/LPN/MT A L037D	RN/LPN/MT A L037D	RT LO41B	RN/LPN/MT A L037D	RN/LPN/MT A L037D	RT LO41B	RN/LPN/MT A L037D	RN/LPN/MT A L037D	RT LO41B	RN/LPN/MT A L037D	RN/LPN/MT A L037D
5	GLOBAL PERIOD			010	010	010	ZZZ	ZZZ	ZZZ	010	010	010	ZZZ	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME			37.0	106.0	57.0	20.0	20.0	0.0	35.0	104.0	57.0	15.0	15.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			3.0	11.0	21.0	0.0	0.0	0.0	3.0	11.0	21.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			34.0	59.0	0.0	20.0	20.0	0.0	32.0	57.0	0.0	15.0	15.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	36.0	36.0	0.0	0.0	0.0	0.0	36.0	36.0	0.0	0.0	0.0
10	PRE-SERVICE														
11	Start: Following visit when decision for surgery or procedure made														
12	Complete pre-service diagnostic & referral forms				3	3					3	3			
13	Coordinate pre-surgery services					5						5			
14	Schedule space and equipment in facility					5						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 (Pull and hang prior imaging studies for MD to review)			3						3					
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				3						3				
22	Obtain vital signs				5						5				
23	Provide pre-service education/obtain consent														
24	Prepare room, equipment, supplies				2						2				
25	Setup scope (non facility setting only)														
26	Prepare and position patient/ monitor patient/ set up IV			2	3					2	3				
27	Sedate/apply anesthesia														
28	Intra-service														
29	Assist physician in performing procedure			30	30		20	20		28	28		15	15	
30	Post-Service														
31	Monitor pt. following service/check tubes, monitors, drains				10						10				
32	Clean room/equipment by physician staff				3						3				
33	Clean Scope														
34	Clean Surgical Instrument Package				0						0				
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				3						3				
38	Discharge day management														
39	Other Clinical Activity (Process, hang, file films)			2						2					
40	End: Patient leaves office														
41	POST-SERVICE Period														
42	Start: Patient leaves office/facility														
43	Conduct phone calls/call in prescriptions														
44	<i>List Number and Level of Office Visits</i>			post	post		post	post		post	post		post	post	
45	99211 16 minutes		16												
46	99212 27 minutes		27												
47	99213 36 minutes		36		1	1					1	1			
48	99214 53 minutes		53												
49	99215 63 minutes		63												
50	99238 12 minutes		12												
51	<i>Total Office Visit Time</i>			0	36	36	0	0	0	0	36	36	0	0	0
52	Other Activity (please specify)														
53	End: with last office visit before end of global period														
54						0			0			0			0

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	AMA/Specialty Society RVS Update Committee Recommendation			64633			64634			64635			64636		
2	Meeting Date: April 2011		CMS	Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), single facet joint			Destruction by neurolytic agent, paravertebral facet joint nerve(s); cervical or thoracic, with image guidance (fluoroscopy or CT), each additional facet joint			Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), single facet joint			Destruction by neurolytic agent, paravertebral facet joint nerve(s); lumbar or sacral, with image guidance (fluoroscopy or CT), each additional facet joint		
3	LOCATION	Code		Non Facility	Non Facility	Facility	Non Facility	Non Facility	Facility	Non Facility	Non Facility	Facility	Non Facility	Non Facility	Facility
55	MEDICAL SUPPLIES		Unit	Non Facility		Facility	Non Facility		Facility	Non Facility		Facility	Non Facility		
56	pack, basic injection	SA041	item	1						1					
57	pack, minimum multi specialty visit	SA048	item	2						2					
58	drape, sterile, c-arm, fluoro	SB008	item	1						1					
59	Syringe 10cc	SC051	item	1						1					
60	Syringe 3cc	SC055	item	1						1					
61	film, dry, radiographic, 8in x 10in	SK025	item	1			1			1			1		
62	bupivacaine 0.5% inj (Marcaine)	SH022	ml	3			3			3			3		
63	kit, probe, radiofrequency, Xli-enhanced RF probe	SA100	item	0						0					
64	cannula (radiofrequency denervation)	SD011	item	2			2			2			2		
65	guide, needle, for localization	SD087	item	1			1			1			1		
66	grounding pad (invoice provided)	not available		1						1					
67	Equipment			Non Facility		Facility	Non Facility		Facility	Non Facility		Facility	Non Facility		
68	stretcher	EF018	min	59			20			59			15		
69	room, mobile C-ARM	EL018	min	38			20			36			15		
70	radiofrequency generator (NEURO)	EQ214	min	38			20			36			15		
71	pulse oximeter	EQ211	min	38			20			36			15		
72	x-ray view box, 4 panel	ER067	min	38			20			36			15		
73	printer, dye sublimation (photo, B&W)	ED031	min	38			20			36			15		
74	film processor, wet	ED025	min	38			20			36			15		
75	film alternator	ER029	min	38			20			36			15		

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
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		CMS													
3	LOCATION	Code		Non Facility	Non Facility	Facility	Non Facility	Non Facility	Facility	Non Facility	Non Facility	Facility	Non Facility	Non Facility	Facility
4				RT LO41B	RN/LPN/MT A L037D	RN/LPN/MT A L037D	RT LO41B	RN/LPN/MT A L037D	RN/LPN/MT A L037D	RT LO41B	RN/LPN/MT A L037D	RN/LPN/MT A L037D	RT LO41B	RN/LPN/MT A L037D	RN/LPN/MT A L037D
5	GLOBAL PERIOD			010	010	010	ZZZ	ZZZ	ZZZ	010	010	010	ZZZ	ZZZ	ZZZ
6	TOTAL CLINICAL LABOR TIME			37.0	116.0	57.0	30.0	30.0	0.0	37.0	116.0	57.0	30.0	30.0	0.0
7	TOTAL PRE-SERV CLINICAL LABOR TIME			3.0	11.0	21.0	0.0	0.0	0.0	3.0	11.0	21.0	0.0	0.0	0.0
8	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			34.0	69.0	0.0	30.0	30.0	0.0	34.0	69.0	0.0	30.0	30.0	0.0
9	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	36.0	36.0	0.0	0.0	0.0	0.0	36.0	36.0	0.0	0.0	0.0
10	PRE-SERVICE														
11	Start: Following visit when decision for surgery or procedure made														
12	Complete pre-service diagnostic & referral forms				3	3					3	3			
13	Coordinate pre-surgery services					5						5			
14	Schedule space and equipment in facility					5						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 (Pull and hang prior imaging studies for MD to review)			3						3					
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				3						3				
22	Obtain vital signs				5						5				
23	Provide pre-service education/obtain consent														
24	Prepare room, equipment, supplies				2						2				
25	Setup scope (non facility setting only)														
26	Prepare and position patient/ monitor patient/ set up IV			2	3					2	3				
27	Sedate/apply anesthesia														
28	Intra-service														
29	Assist physician in performing procedure			30	30		30	30		30	30		30	30	
30	Post-Service														
31	Monitor pt. following service/check tubes, monitors, drains				10						10				
32	Clean room/equipment by physician staff				3						3				
33	Clean Scope														
34	Clean Surgical Instrument Package				10						10				
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				3						3				
38	Discharge day management														
39	Other Clinical Activity (Process, hang, file films)			2						2					
40	End: Patient leaves office														
41	POST-SERVICE Period														
42	Start: Patient leaves office/facility														
43	Conduct phone calls/call in prescriptions														
44	<i>List Number and Level of Office Visits</i>			post	post		post	post		post	post		post	post	
46	99211 16 minutes		16												
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49	99214 53 minutes		53												
50	99215 63 minutes		63												
51	99238 12 minutes		12												
52	<i>Total Office Visit Time</i>			0	36	36	0	0	0	0	36	36	0	0	0
53	Other Activity (please specify)														
54	End: with last office visit before end of global period														

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57	pack, minimum multi specialty visit	SA048	item	2						2					
58	drape, sterile, c-arm, fluoro	SB008	item	1						1					
59	Syringe 10cc	SC051	item	1						1					
60	Syringe 3cc	SC055	item	1						1					
61	film, dry, radiographic, 8in x 10in	SK025	item	1			1			1			1		
62	bupivacaine 0.5% inj (Marcaine)	SH022	ml	3			3			3			3		
63	kit, probe, radiofrequency, Xli-enhanced RF probe	SA100	item	1						1					
64	cannula (radiofrequency denervation)	SD011	item	2			2			2			2		
65	guide, needle, for localization	SD087	item	1			1			1			1		
66	grounding pad (invoice provided)	not available		1						1					
67	Equipment			Non Facility		Facility	Non Facility		Facility	Non Facility		Facility	Non Facility		
68	stretcher	EF018	min	116			30			116			30		
69	room, mobile C-ARM	EL018	min	38			30			38			30		
70	radiofrequency generator (NEURO)	EQ214	min	38			30			38			30		
71	pulse oximeter	EQ211	min	38			30			38			30		
72	x-ray view box, 4 panel	ER067	min	38			30			38			30		
73	printer, dye sublimation (photo, B&W)	ED031	min	38			30			38			30		
74	film processor, wet	ED025	min	38			30			38			30		
75	film alternator	ER029	min	38			30			38			30		

Typical Patient (64633X)

A 65-year-old female involved in a flexion extension injury from an automobile accident presents with constant neck pain. The patient's history includes imaging studies with findings of minimal degenerative disc disease and cervical spondylosis. The patient had no relief with conservative treatments such as, physical therapy, NSAIDs, or trigger point injections. Previous trials of cervical medial branch blocks provided significant short-term relief. She undergoes radiofrequency neurotomy of the two medial branch nerves innervating the symptomatic facet joint.

Typical Patient (64634X)

A 65-year-old female involved in a flexion extension injury from an automobile accident presents with constant neck pain. The patient's history includes imaging studies with findings of minimal degenerative disease and cervical spondylosis. The patient received no relief with conservative treatments such as, physical therapy, NSAIDs, or trigger point injections. Previous trials of cervical medial branch blocks provided significant short-term relief. She undergoes radiofrequency neurotomy two medial branch nerves innervating the additional symptomatic facet joint.

Typical Patient (64635X)

A 65-year-old female involved in a flexion-extension injury from an automobile accident, presents with constant low back pain. The patient's history includes imaging studies with findings of minimal degenerative disc disease and no facet arthropathy. The patient had no relief with conservative treatments such as physical therapy, NSAIDs, or trigger point injections. Previous trials of lumbar medial branch blocks provided significant short-term relief of her low back pain. She undergoes radiofrequency neurotomy of the two medial branch nerves innervating the symptomatic facet joint.

Typical Patient (64636X)

A 65-year-old female involved in a flexion extension injury from an automobile accident presents with constant low back pain. The patient's history includes imaging studies with findings of minimal degenerative disc disease and no facet arthropathy. The patient had no relief with conservative treatments such as, physical therapy, NSAIDs, or trigger point injections. Previous trials of lumbar medial branch blocks provided significant short-term relief. She undergoes radiofrequency neurotomy of the two medial branch nerves innervating the additional symptomatic facet joint.

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Identified through the Site of Service Anomaly Screen

February 2011

Repair of Eye Wound

In September 2007, the RUC's Relativity Assessment Workgroup (formerly Five-Year Review Identification Workgroup) identified CPT code 65285 *Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue* and 68810 *Probing of nasolacrimal duct, with or without irrigation* as potentially misvalued through the Site-of-Service Anomaly screen. These services were initially priced in the facility setting, i.e. have hospital visits and full discharge management services associated with them, and are now being performed in the outpatient setting more than 50% of the time, according to the Medicare claims data. CMS requested the RUC review these site of service anomalies services. In February 2008, the RUC reviewed these services and accepted the evidence presented by the specialty society that 65285 required inpatient services and an overnight inpatient stay. CMS agreed with the RUC's recommendations for CY 2009. It was also suggested by the specialty that CPT code 65285 not be included on the ASC list and a CPT Assistant article should be written to describe the appropriate use of this code. Following the RUC's recommendation, CMS included code 65285 in Table 15 of the 2011 Proposed Rule and asked the RUC to re-review the physician work of 65285.

The RUC discussed the specialty society's survey results of CPT code 65285 from 30 ophthalmologists. The agreed with the specialty regarding its compelling evidence that the physician work value has changed substantially since the service's original review during the Harvard study. This service had never been RUC surveyed in the past and the RUC agreed with the specialty that this service is the most serious eye trauma service there is, where there is typically a corneal scar or cut and the internal contents of the eye have been extruded. In the past, techniques and procedures limited the success and recovery from such an injury, and the eye was more often extracted. Today, the microsurgery surgery techniques have improved and there is an enhanced knowledge base for caring for these patients. In addition, new high sheer elastics allow the surgeon to re-inflate the eye with a substance similar to jelly that allows the eye to retain its shape and form without leaking while the surgeon attempts to suture the eye. Although the typical patient has not changed (non-Medicare young patient) the intensity of and complexity of the procedure has increased due to enhanced microsurgical technology, improvements in suture and graft materials, and new pharmaceuticals that control post operative complications. In addition, the injuries repaired are more severe and extensive than 20 years ago, as documented in several peer-reviewed articles. The RUC agreed with the compelling evidence presented and the specialty's 25th percentile work relative value survey results, indicating 16.00 work RVUs for code 65285.

The RUC also concluded that, based on discussions with the specialty, the pre-service time package should be changed to package 3 from package 4 as these patients were considered by the RUC to have less co-morbidities and therefore less difficult to treat. In addition, the RUC agreed that the patient today is seen in an outpatient facility which would include a subsequent observation visit (99217) rather than the current discharge day management service (99238).

The RUC unanimously agreed that the typical service is emergent, difficult, and highly intense. In addition, these patients typically have extensive post-operative follow up involving a subsequent observation and six office visits. To ensure the recommended work RVU is relative across the RBRVS, the RUC used magnitude estimation by referencing the following four services in comparison to the work of 65285 to support the work value of this service at 16.00 RVUs.

65710 - *Keratoplasty (corneal transplant); anterior lamellar* (work RVU = 14.45, 90 minutes intra-service time). The RUC considered the service of code 65285 clearly more physician work and emergent than code 65710, with greater total time of 372 minutes compared to 317 minutes. However, both services have similar extensive post operative follow up care.

35266 - *Repair blood vessel with graft other than vein; upper extremity* (work RVU = 15.83, 90 minutes intra-service time). RUC members compared the service of 35266 and agreed that 65285 is more overall work, highly intense, and emergent, than 35266 with total time of 372 minutes compared to 337 minutes for the reference code.

65750 - *Keratoplasty (corneal transplant); penetrating (in aphakia)* (work RVU = 16.90, 90 minutes intra-service time) RUC members compared the service of reference code 65750 to 65285 and agreed that the surveyed code is less overall physician work with similar post operative follow up care and should be valued slightly less than the reference code.

43420 - *Closure of esophagostomy or fistula; cervical approach* (work RVU = 16.78, 90 minutes intra-service time). RUC members compared the service of reference code 43420 to 65285 and agreed that the surveyed code is less overall work than 43420, with total time of 372 minutes compared to 520 minutes for the reference code.

The RUC recommends a relative work value of 16.00 for CPT code 65285.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
▲65285	P1	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue (65280 and 65285 are not used for repair of a surgical wound.)	090	16.00

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

CPT Code:65285 Tracking Number Original Specialty Recommended RVU: **17.00**
Presented Recommended RVU: **17.00**
Global Period: 090 RUC Recommended RVU: **16.00**

CPT Descriptor: Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue (65280 and 65285 are not used for repair of surgical wound)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25 year old male is struck in the face with a blunt object causing a corneoscleral laceration with iris prolapse. Surgical repair is performed

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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

Percent of survey respondents who stated they perform the procedure; In the hospital 100% , 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 13% , Kept overnight (less than 24 hours) 47% , Admitted (more than 24 hours) 40%

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 21%

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? 30%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The medical history is reviewed. Any orbital images are reviewed for the presence of orbital fractures or foreign bodies. A handlight exam is performed and the injured eye identified. The risks and benefits of the procedure are reviewed with the family.

Description of Intra-Service Work: The patient is positioned in the operating room and prepped for surgery. An eyelid speculum is placed. A conjunctival peritomy is performed over the laceration and extend posteriorly so that the entire extent of the scleral laceration can be identified. Where this extends beneath an extraocular muscle, the muscle is secured on a suture and disinserted from the globe. The scleral wound is closed with interrupted sutures after repositioning any visibly prolapsed choroid. The corneal wound is examined. Iris is gently repositioned into the anterior chamber with irrigation and/or blunt instruments. The anterior chamber is reformed with balanced salt solution. The corneal wound is closed with 10-0 interrupted nylon sutures. The extraocular muscle is reattached to the original insertion site. Antibiotics are injected subconjunctivally. Topical antibiotics and steroids are administered.

Description of Post-Service Work: The outcome of the procedure is reviewed with the patient and family. The operative note is dictated. The next day after examination is concluded the patient is discharged and instructions are provided. Follow-up visits are scheduled for days 3 and 4 immediately after surgery. Additional postoperative visits are scheduled after 1 week, 2 weeks, 1 month, 2 months and 3 months after the repair.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011				
Presenter(s):	Stephen A Kamenetzky, M.D.					
Specialty(s):	Ophthalmology					
CPT Code:	65285					
Sample Size:	200	Resp N:	30	Response: 15.0 %		
Sample Type:	Random Additional Sample Information: This code was surveyed previously in 2007 but the 5Yr Identification Workgroup (now RAW workgroup) deemed that a survey was not necessary. We reached out to the previous respondents as well as a random list of members who indicated an interest in trauma surgery.					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	1.00	4.00	7.00	121.00
Survey RVW:		14.00	16.00	17.00	21.50	25.00
Pre-Service Evaluation Time:				30.00		
Pre-Service Positioning Time:				10.00		
Pre-Service Scrub, Dress, Wait Time:				20.00		
Intra-Service Time:		45.00	90.00	90.00	120.00	150.00
Immediate Post Service-Time:	30.00					
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):	40.00	99231x 0.00	99232x 1.00	99233x 0.00		
Discharge Day Mgmt:	38.00	99238x 1.00	99239x 0.00			
Office time/visit(s):	171.00	99211x 0.00	12x 1.00	13x 5.00	14x 1.00	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); 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:

4 - FAC Difficult Patient/Difficult Procedure

CPT Code:	65285	Recommended Physician Work RVU: 17.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		30.00	40.00	-10.00
Pre-Service Positioning Time:		10.00	3.00	7.00
Pre-Service Scrub, Dress, Wait Time:		20.00	20.00	0.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:	30.00			
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:	38.00	99238x 1.0	99239x 0.0	
Office time/visit(s):	154.00	99211x 0.00	12x 1.00	13x 6.00 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
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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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
65750	090	16.90	RUC Time

CPT Descriptor Keratoplasty (corneal transplant); penetrating (in aphakia)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
65750	010	16.90	RUC Time	610

CPT Descriptor 1 Keratoplasty (corneal transplant); penetrating (in aphakia)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
49002	090	17.63	RUC Time	5,836

CPT Descriptor 2 Reopening of recent laparotomy

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
43420	090	16.78	RUC Time

CPT Descriptor Closure of esophagostomy or fistula; cervical approach

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 7 % of respondents: 23.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 65285	<u>Key Reference CPT Code:</u> 65750	<u>Source of Time</u> RUC Time
Median Pre-Service Time	60.00	40.00	
Median Intra-Service Time	90.00	90.00	
Median Immediate Post-service Time	30.00	20.00	
Median Critical Care Time	0.0	0.00	
Median Other Hospital Visit Time	0.0	0.00	
Median Discharge Day Management Time	38.0	0.00	
Median Office Visit Time	154.0	138.00	
Prolonged Services Time	0.0	0.00	
Median Subsequent Observation Care Time	0.0	0.00	
Median Total Time	372.00	288.00	

Other time if appropriate		
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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	4.29	3.57
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.14	3.14
--	------	------

Urgency of medical decision making	4.71	2.86
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.43	4.43
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Physical effort required	4.14	3.86
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.57	4.00
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Outcome depends on the skill and judgment of physician	4.57	4.43
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Estimated risk of malpractice suit with poor outcome	4.00	3.71
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	4.57	3.57
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Intra-Service intensity/complexity	4.43	3.71
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Post-Service intensity/complexity	4.29	3.86
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Additional Rationale and Comments

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

This code is being reviewed because of a continuing concern from CMS regarding site of service issues. The RUC considered the code in 2008 and accepted the evidence submitted by the society that the procedure required inpatient services and an overnight inpatient stay. CMS database indicated that it was an outpatient procedure. The Academy believes that the reason for the discrepancy was a combination of miscoding and/or hospital observation policies and

proposed educational efforts and coding language to mitigate the problem. However CMS again raised the site of service issue in the 2011 proposed rule and indicated that the work for visits for hospital care and discharge management would be removed unless the code was resurveyed. CPT modified the descriptor to make clear that the code was not to be used for surgical wound repair and the Academy resurveyed.

The survey was sent to the original respondents as well as a new random list of members who indicated an interest in trauma services in our membership data base. We struggled to meet the required numbers of responses and went back to RUC staff to inquire if we could reach out to the previous respondents who did not complete a second survey to ask the missing site of service questions that have been added since the previous survey and add that info to their previous responses. Permission was granted to proceed with a mini-survey for 15 individuals (10 responded) and then their old data along with their responses on site of service were tabulated.

The Academy's consensus panel recommends the median WRVU 17.0 for code 65285. The reference code 65750 is RUC reviewed with the same IST, is less complex in all parameters of intensity and complexity and has a WRVU of 16.9. For comparison, 35266 *Repair of vessel with graft other than vein, upper extremity* is RUC reviewed with WRVU of 15.83 with similar pre, intra and post service times. 43420 *Closure of esophagostomy or fistula, cervical approach* is also RUC reviewed and has a WRVU of 16.78 and comparable pre, intra and post service times. Our recommendation is consistent within the family of complex anterior segment codes and previous decisions of the RUC for other complicated surgical procedures.

Compelling Evidence

We believe there is compelling evidence that this code is undervalued. The code has never been RUC reviewed so the current values and times represent the original Harvard data. In addition the patient population treated has changed so that many eyes that were previously enucleated primarily because of severe trauma are now repaired. We are able to do this because of advances in microsurgical techniques, improvements in suture and graft materials, and advent of new pharmaceuticals (primarily antibiotics and anti-inflammatory medications) that better control post-operative complications. Thus the injuries repaired are more severe and extensive than 20 years ago. This information is documented in several peer-reviewed articles that are attached.

Further Survey Info

This is an infrequently performed procedure in the Medicare age group which we believe accounts for the anomaly for site of service in the data base. The severe injury associated with use of the code usually occurs in a younger patient who has had trauma. The service represents one of the more complex procedures performed by ophthalmologists, typically requiring an overnight hospital admission postoperatively for IV antibiotics and close observation because of the significant anatomical disruption associated with this type of injury.

The AAO surveyed 200 ophthalmologists and received 30 responses for a completion rate of 15%. All felt that the vignette was typical. All performed the service in the hospital. Twenty six of 30 either kept the patient overnight or admitted the patient to the facility. The 25th percentile WRVU was 16.0 and the median WRVU 17.0 with a median intra-service time of 90 minutes. Both the 25th percentile and the median intraservice times were 90 minutes. Preservice package 4 (difficult patient/difficult procedure) was used. The total time for this package was less than the times in the survey. The primary reference code chosen, CPT 65750 (*keratoplasty (corneal transplant); penetrating (in aphakia)*) is RUC-reviewed code with a WRVU of 16.9 and an intra-service time of 90 minutes.

The Academy's consensus panel reviewed the survey results. For all of the intensity- complexity measures considered, 65285 had a higher value than the reference code, with urgency of medical decision making, complexity of medical information and risk of complications showing particularly large positive variances. The pre-service time is long, but that is because there is significant clinical material to be collected and reviewed. Consultation with multiple medical specialties is usually required to plan the surgical procedure in these patients who frequently have other serious injuries. Pre-service scrub, dress and wait is time is also longer than that for a typical ophthalmology procedures, because of the required special precautions for protection of the eye and induction of general anesthesia in a patient with an open eye wound.

Post-operative care is also intense with multiple visits in the 7-10 days after surgery to gauge healing, adjust medications and watch for signs of endophthalmitis, a common and devastating complication related to this type of injury. Six 99213 and one 99212 visits occur in the global period along with a hospital visit and discharge day. The surveys indicated there is one visit with an extended problem-focused exam and moderate decision making (mid-level) visit on the day of the procedure. We are defining the visit in this fashion because of the issues raised about the

Specialty	Frequency	Percentage	%
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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 65285

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 Committee
Summary of Recommendations
Identified through the Harvard Valued – Utilization over 100,000 Screen

February 2011

Radiologic Examination – Spine

In October 2009, CPT code 72110 was identified through the Five-Year Identification Workgroup (now called the Relativity Assessment Workgroup) Harvard Valued- Utilization over 100,000 Screen. CPT codes, 72100, 72114 and 72120 were added as part of the code family and the specialties submitted an Action Plan to refer codes 72114 and 72120 to the CPT Editorial Panel to clarify the number of views completed for these two spine services.

72100 Radiologic examination, spine, lumbosacral; 2 or 3 views

The RUC reviewed the specialty survey results from 48 radiologists, orthopaedic surgeons and spine surgeons for CPT code 72100. The RUC recommends pre-service time of 1 minute, intra-service time of 3 minutes and post service time of 2 minutes. The RUC analyzed the survey's estimated physician work and agreed that these data support the current work value and survey's 25th percentile of 0.22. To further justify this recommended value, the RUC compared the surveyed code to key reference service CPT code 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views* (work RVU= 0.27 and total time= 5 minutes). The RUC agreed that the reference code and the surveyed code are analogous physician services and should be valued similarly. In addition, the RUC compared CPT code 72100 to the MPC code 71020 *Radiologic examination, chest, 2 views, frontal and lateral* (work RVU= 0.22 and total time= 5 minutes). The RUC noted that these services have highly similar physician work and required views and should be valued identically. Finally, the RUC reviewed reference code 88311 *Decalcification procedure* (work RVU= 0.24) and noted that the reference code should be valued slightly higher than the surveyed code due to greater total time of 7 minutes compared to 6 minutes. The RUC agreed that the current physician work value, substantiated by the survey's 25th percentile, is an accurate depiction of the physician work involved. **The RUC recommends a work RVU of 0.22 for CPT code 72100.**

72110 Radiologic examination, spine, lumbosacral; minimum of 4 views

The RUC reviewed and agreed with the specialty survey results from 48 radiologists, orthopaedic surgeons and spine surgeons for CPT code 72110. The RUC recommends pre-service time of 1 minute, intra-service time of 5 minutes and post service time of 2 minutes. The RUC analyzed the survey's estimated physician work and agreed that these data support the current work value of 0.31, which is slightly less than the survey's median estimated value of 0.32. To further justify this recommended value, the RUC compared the surveyed code to key reference CPT code 74022 *Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest* (work

RVU= 0.32 and total time= 5 minutes). The RUC agreed that the reference code and the surveyed code are analogous physician services and should be valued similarly. In addition, the RUC compared CPT code 72110 to the MPC code 71020 *Radiologic examination, chest, 2 views, frontal and lateral* (work RVU= 0.22 and total time= 5 minutes). The RUC agreed that the surveyed code should be valued higher due to greater total time, 8 minutes compared to 5 minutes, and a greater minimum number of views, 4 views compared to 2 views. The RUC agreed that the current physician work value, substantiated by the survey's median work value, is an accurate portrayal of the physician work involved. There is no compelling evidence to increase the value. **The RUC recommends a work RVU of 0.31 for CPT code 72110.**

72114 Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views

The RUC reviewed and agreed with the specialty survey results from 48 radiologists, orthopaedic surgeons and spine surgeons for CPT code 72114. The RUC recommends pre-service time of 1 minute, intra-service time of 5 minutes and post service time of 2 minutes. The RUC analyzed the survey's estimated physician work and agreed that these data do not support the current physician work value of 0.36. The RUC agreed that the specialties' survey median work value of 0.32 accurately values the physician work involved. To further justify this value, the RUC compared the surveyed code to key reference CPT code 74022 *Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest* (work RVU= 0.32 and total time= 5 minutes). The RUC agreed that these services have analogous physician work and should be valued similarly. In addition, the RUC compared CPT code 72114 to the reference code 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views* (work RVU= 0.27 and total time= 5 minutes). The RUC noted that the reference code and the surveyed code have similar physician work, but the code 72114 should be valued higher than the reference code due to greater total time, 8 minutes and 5 minutes, respectively. Finally, the RUC reviewed reference code 92542 *Positional nystagmus test, minimum of 4 positions, with recording* (work RVU= 0.33) and noted that the reference code should be valued slightly higher than the surveyed code due to greater total time of 9 minutes compared to 8 minutes. The RUC agreed that the current physician work value, substantiated by the survey's median work value, is an accurate portrayal of the physician work involved. **The RUC recommends a work RVU of 0.32 for CPT code 72114.**

72120 Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views

The RUC reviewed the specialty survey results from 48 radiologists, orthopaedic surgeons and spine surgeons for CPT code 72120. The RUC recommends pre-service time of 1 minute, intra-service time of 3 minutes and post service time of 2 minutes. The RUC analyzed the survey's estimated physician work and agreed that these data support the current work value of 0.22, which is the survey's 25th percentile estimated value. To further justify this value, the RUC compared the surveyed code to key reference CPT code 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views* (work RVU= 0.27 and total time= 5 minutes). The RUC agreed that these services have analogous physician work and should be valued similarly. In addition, the RUC compared CPT code 72120 to MPC code 71020 *Radiologic examination, chest, 2 views, frontal and lateral* (work RVU= 0.22 and total time= 5 minutes). RUC noted that the reference code and the surveyed code have similar physician work and code 72120 should be valued identically to code 71020 due to similar total time, 6 minutes and 5 minutes, respectively. Finally, the RUC compared this service in relation to code 72100. The surveyed service is typically performed in the lateral projection, with the patient performing flexion and extension maneuvers. The RUC agreed there is slightly greater work required in the evaluation of the spine itself

required in code 72120 than on the 72100 procedure; however, there is more anatomy outside the spine revealed on the 72100 exam, as well as the need to evaluate the spine in two projections. The RUC, and the specialties agreed that these exams are essentially equivalent in terms of physician work. Finally, the RUC reviewed reference code 88311 *Decalcification procedure* (work RVU= 0.24) and noted that the reference code should be valued slightly higher than the surveyed code due to greater total time of 7 minutes compared to 6 minutes. **The RUC recommends a work RVU of 0.22 for CPT code 72120.**

Work Neutrality

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

Practice Expense:

The RUC discussed at length the direct practice expense inputs for these radiologic examination services under review. The RUC agreed with most of the recommended direct inputs and made minor edits to those within CPT code 72120.

CPT Code	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
72100	H1	Radiologic examination, spine, lumbosacral; 2 or 3 views	XXX	0.22 (No Change)
72110	H2	minimum of 4 views	XXX	0.31 (No Change)
▲72114	H3	complete, including bending views, <u>minimum of 6</u> views	XXX	0.32
▲72120	H4	<u>bending views only, minimum of 4 2 or 3 views</u> (For a combined computed tomography (CT) or computed tomographic angiography abdomen and pelvis study, see 74174, 74176-74178)	XXX	0.22 (No Change)

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

CPT Code: 72100	Tracking Number	Original Specialty Recommended RVU: 0.22
		Presented Recommended RVU: 0.22
Global Period: XXX		RUC Recommended RVU: 0.22

CPT Descriptor: Radiologic examination, spine, lumbosacral; 2 or 3 views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Sixty-eight year old female with lumbar pain and no history of trauma. Rule out arthritis.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work:

Review clinical history

Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:

Supervise technologist performing the examination.

Interpret radiographs of the lumbosacral spine.

Compare with prior studies, if applicable.

Dictate report.

Description of Post-Service Work:

Review and sign report.

Communicate findings to referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011			
Presenter(s):	William Creevy, MD; Zeke Silva, MD; Geraldine McGinty, MD; William Sullivan, MD; William Donovan, MD				
Specialty(s):	AAOS; ACR; ASNR; NASS				
CPT Code:	72100				
Sample Size:	500	Resp N:	48	Response: 9.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	50.00	200.00	400.00
Survey RVW:		0.17	0.22	0.25	0.27
Pre-Service Evaluation Time:				1.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		1.00	2.00	3.00	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 0.00	99239x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 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); 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:	72100	Recommended Physician Work RVU: 0.22		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		1.00	0.00	1.00
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:		3.00		
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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74020	XXX	0.27	RUC Time

CPT Descriptor Radiologic examination, abdomen; complete, including decubitus and/or erect views**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	14,267,661

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
	XXX		RUC Time	

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
71020	XXX	0.22	RUC Time

CPT Descriptor Radiologic examination, chest, 2 views, frontal and lateral;**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 13 % of respondents: 27.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 72100	<u>Key Reference CPT Code:</u> 74020	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	1.00	
Median Intra-Service Time	3.00	3.00	
Median Immediate Post-service Time	2.00	1.00	
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	6.00	5.00	
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	1.70	2.33
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.65	2.26
--	------	------

Urgency of medical decision making	2.26	2.26
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.32	1.61
--------------------------	------	------

Physical effort required	1.48	1.33
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.70	2.17
---	------	------

Outcome depends on the skill and judgment of physician	2.50	2.46
--	------	------

Estimated risk of malpractice suit with poor outcome	2.42	2.77
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.94	2.56
----------------------------------	------	------

Intra-Service intensity/complexity	2.00	2.54
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Post-Service intensity/complexity	2.19	2.58
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Additional Rationale and Comments

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

Background

72100, Radiologic examination, spine, lumbosacral; 2 or 3 views is presented for survey and review by the RUC as a part of a family of Spinal X-ray codes (72100, 72110, 72114, 72120).

The RUC's 5-Year Review ID workgroup (since renamed the RUC Relativity Assessment workgroup) identified code 72110, Radiologic examination, spine, lumbosacral; minimum of 4 views, for review under its **"Harvard valued, utilization greater than 100,000"** screen for the February 2010 workgroup meeting. At the February 2010 meeting the societies submitted an action plan recommending maintenance of the current values for the family, based on their maintenance at the first 5 Year Review, and by crosswalk to other RUC-approved diagnostic X-Ray codes. This was the same methodology that was approved by the RUC for a series of lower extremity x-ray codes at the October 2009 meeting. The workgroup agreed that surveying low RVW codes with little time is difficult, however they were concerned with the apparently discrepant relationship between 72110, with a RVW of 0.31 and 6 minutes intra-time and 72120, Radiologic examination, spine, lumbosacral, bending views only, minimum of 4 views with a RVW of 0.22, also with 6 minutes.

At the April 2010 meeting of the 5-Year Review ID workgroup the societies presented a revised recommendation calling for the revision of the descriptors for 72120 and 72114 in order to clarify the progressive rank order relationships among codes 72100, 72110, 72114, and 72120. The workgroup agreed with this recommendation. The descriptors were revised at the October 2010 Editorial Panel meeting, and the societies have surveyed all four codes for this meeting.

Time and RVW recommendation

The societies surveyed code 72100 along with 72110, 72114, and 72120. The survey sample was a random sample from each participating society and we received a total of 48 survey responses.

Our survey median RVW was 0.25 with a total time of 6 minutes. The 25th % RVW was 0.22. Our median times were 1 minute pre-time for day of evaluation, 3 minutes intra-time, and 2 minutes immediate post-time. The most commonly chosen reference code was CPT code 74020, *Radiologic examination, abdomen; complete, including decubitus and/or erect views* with a work RVU of 0.27 and 5 minutes total time (1 minute pre-service evaluation time, 3 minutes intra-time and 1 minute immediate post-service time). 74020 was surveyed in 2005 and has an IWPUT of 0.075.

We recommend maintaining the current RVW of 0.22 for 72100, which is also our survey 25% RVW. This value is also identical to 71020, *Radiologic examination, chest, 2 views, frontal and lateral*;

We are recommending a total of 6 minutes time which is the same as our total survey time and the same as the Harvard assigned times.

Below is a table showing the four codes surveyed, their minimum number of views, total recommended times, current (Harvard) total times, Recommended work RVUs, Current (Harvard) work RVUs, the recommended IWPUTs and the current IWPUTs.

CPT Code	Bending or Non-Bending	Minimum Number of Views	Recommended Total Time	Current (Harvard) Total Time	Recommended Work RVU	Current (Harvard) Work RVU	Recommended IWPUT	Current IWPUT
72100	Non-bending	2 or 3	6	6	0.22	0.22	0.044	0.037
72120	Bending	2 or 3	6	6	0.22	0.22	0.044	0.037
72110	Non-bending	4	8	6	0.31	0.31	0.044	0.052
72114	Bending	6	8	6	0.36	0.36	0.053	0.060

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) 72100

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 Orthopaedics How often? Commonly

Specialty Diagnostic Radiology How often? Commonly

Specialty Family Practice How often? Sometimes

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? 1,824,948 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2009 Medicare Data

Specialty orthopaedics Frequency 911379 Percentage 49.93 %

Specialty Diagnostic Radiology Frequency 291079 Percentage 15.94 %

Specialty Family Practice Frequency 123001 Percentage 6.73 %

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 72100

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: 72110 Tracking Number Original Specialty Recommended RVU: **0.31**
 Presented Recommended RVU: **0.31**
 Global Period: XXX RUC Recommended RVU: **0.31**

CPT Descriptor: Radiologic examination, spine, lumbosacral; minimum of 4 views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Twenty-seven year old male presenting with trauma to the lumbosacral spine from auto accident.

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 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Review clinical history

Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:

Supervise technologist performing the examination.

Interpret radiographs of the lumbosacral spine.

Compare with prior studies, if applicable.

Dictate report.

Description of Post-Service Work:

Review and sign report.

Communicate findings to referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011			
Presenter(s):	William Creevy, MD; Zeke Silva, MD; Geraldine McGinty, MD; William Sullivan, MD; William Donovan, MD				
Specialty(s):	AAOS; ACR; ASNR; NASS				
CPT Code:	72110				
Sample Size:	500	Resp N:	48	Response: 9.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	50.00	150.00	238.00
Survey RVW:		0.21	0.27	0.32	0.35
Pre-Service Evaluation Time:				1.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		2.00	3.00	5.00	6.00
Immediate Post Service-Time:	<u>2.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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); 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:	72110	Recommended Physician Work RVU: 0.31		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		1.00	0.00	1.00
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:	<u>2.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74022	XXX	0.32	RUC Time

CPT Descriptor Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	14,267,661

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
	XXX		RUC Time	

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74020	XXX	0.27	RUC Time

CPT Descriptor Radiologic examination, abdomen; complete, including decubitus and/or erect 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: 18 % of respondents: 37.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 72110	<u>Key Reference CPT Code:</u> 74022	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	1.00	
Median Intra-Service Time	5.00	3.00	
Median Immediate Post-service Time	2.00	1.00	
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	8.00	5.00	
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	1.91	2.70
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.91	2.40
--	------	------

Urgency of medical decision making	2.72	2.45
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.19	1.74
--------------------------	------	------

Physical effort required	1.74	1.44
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.98	2.44
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Outcome depends on the skill and judgment of physician	2.77	2.63
--	------	------

Estimated risk of malpractice suit with poor outcome	2.73	2.98
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.16	2.72
----------------------------------	------	------

Intra-Service intensity/complexity	2.33	2.88
------------------------------------	------	------

Post-Service intensity/complexity	2.66	2.84
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Additional Rationale and Comments

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

Background

72110, Radiologic examination, spine, lumbosacral; minimum of 4 views is presented for survey and review by the RUC as a part of a family of Spinal X-ray codes (72100, 72110, 72114, 72120).

The RUC's 5-Year Review ID workgroup (since renamed the RUC Relativity Assessment workgroup) identified code 72110, Radiologic examination, spine, lumbosacral; minimum of 4 views, under its "Harvard valued, utilization greater than 100,000" screen for the February 2010 workgroup meeting. At the February 2010 meeting the societies submitted an action plan recommending maintenance of the current values for the family, based on their maintenance at the first 5 Year Review, and by crosswalk to other RUC-approved diagnostic X-Ray codes. This was the same methodology that was approved by the RUC for a series of lower extremity x-ray codes at the October 2009 meeting. The workgroup agreed that surveying low RVW codes with little time is difficult, however they were concerned with the apparently discrepant relationship between 72110, with a RVW of 0.31 and 6 minutes intra-time and 72120, Radiologic examination, spine, lumbosacral, bending views only, minimum of 4 views with a RVW of 0.22, also with 6 minutes.

At the April 2010 meeting of the 5-Year Review ID workgroup the societies presented a revised recommendation calling for the revision of the descriptors for 72120 and 72114 in order to clarify the progressive rank order relationships among codes 72100, 72110, 72114, and 72120. The workgroup agreed with this recommendation. The descriptors were revised at the October 2010 Editorial Panel meeting, and the societies have surveyed all four codes for this meeting.

Time and RVW recommendation

The societies surveyed code 72110 along with 72100, 72114, and 72120. The survey sample was a random sample from each participating society and we received a total of 48 survey responses.

Our survey median RVW was 0.32 with a total time of 8 minutes. Our median times were 1 minute pre-time for day of evaluation, 5 minutes intra-time, and 2 minutes immediate post-time.

The most commonly chosen reference code was CPT code 74022, *Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest* with a work RVU of 0.31 and 5 minutes total time (1 minute pre-service evaluation time, 3 minutes intra-time and 1 minute immediate post-service time). 74022 was surveyed in 2005 and has an IWP/UT of 0.092.

We recommend maintaining the current RVW of 0.31 for 72110 which is essentially identical to our survey median RVW of 0.32.

We are recommending a total of 8 minutes time which is the same as our total survey time and more than the currently assigned Harvard times, yet we are not asking for any increase in work RVU.

Below is a table showing the four codes surveyed, their minimum number of views, total recommended times, current (Harvard) total times, Recommended work RVUs, Current (Harvard) work RVUs, the recommended IWP/UTs and the current IWP/UTs.

CPT Code	Bending or Non-Bending	Minimum Number of Views	Recommended Total Time	Current (Harvard) Total Time	Recommended Work RVU	Current (Harvard) Work RVU	Recommended IWP/UT	Current IWP/UT
72100	Non-bending	2 or 3	6	6	0.22	0.22	0.044	0.037
72120	Bending	2 or 3	6	6	0.22	0.22	0.044	0.037
72110	Non-Bending	4	8	6	0.31	0.31	0.044	0.052
72114	Bending	6	8	6	0.36	0.36	0.053	0.060

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) 72110

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 Orthopaedics How often? Commonly

Specialty Family Practice How often? Rarely

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	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 922,679 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2009 Medicare Utilization

Specialty Diagnostic Radiology	Frequency 364274	Percentage 39.48 %
Specialty Orthopaedic Surgery	Frequency 248847	Percentage 26.97 %
Specialty Family Practice	Frequency 64957	Percentage 7.04 %

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 72110

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: 72114	Tracking Number	Original Specialty Recommended RVU: 0.36
		Presented Recommended RVU: 0.32
Global Period: XXX		RUC Recommended RVU: 0.32

CPT Descriptor: Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Thirty-two year old female presenting with trauma to the lumbosacral spine from auto accident. Clinical concern for instability.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work:

Review clinical history

Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:

Supervise technologist performing the examination.

Interpret radiographs of the lumbosacral spine.

Compare with prior studies, if applicable.

Dictate report.

Description of Post-Service Work:

Review and sign report.

Communicate findings to referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011			
Presenter(s):	William Creevy, MD; Zeke Silva, MD; Geraldine McGinty, MD; William Sullivan, MD; William Donovan, MD				
Specialty(s):	AAOS, ACR, ASNR, NASS				
CPT Code:	72114				
Sample Size:	500	Resp N:	48	Response: 9.6 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	23.00	100.00	200.00
Survey RVW:		0.18	0.27	0.32	0.40
Pre-Service Evaluation Time:				1.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		2.00	3.00	5.00	6.00
Immediate Post Service-Time:	<u>2.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00		
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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); 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:	72114	Recommended Physician Work RVU: 0.36		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		1.00	0.00	1.00
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:	<u>2.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74022	XXX	0.32	RUC Time

CPT Descriptor Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	14,267,661

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74020	XXX	0.27	RUC Time

CPT Descriptor Radiologic examination, abdomen; complete, including decubitus and/or erect 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: 23 % of respondents: 47.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 72114	<u>Key Reference CPT Code:</u> 74022	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	1.00	
Median Intra-Service Time	5.00	3.00	
Median Immediate Post-service Time	2.00	1.00	
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	8.00	5.00	
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	1.91	2.71
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.87	2.48
--	------	------

Urgency of medical decision making	2.70	2.43
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.70	1.84
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Physical effort required	1.74	1.53
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	2.45
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Outcome depends on the skill and judgment of physician	2.85	2.59
--	------	------

Estimated risk of malpractice suit with poor outcome	2.81	2.91
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.30	2.72
----------------------------------	------	------

Intra-Service intensity/complexity	2.38	2.87
------------------------------------	------	------

Post-Service intensity/complexity	2.53	2.85
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Additional Rationale and Comments

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

Background

72114, Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views is presented for survey and review by the RUC as a part of a family of Spinal X-ray codes (72100, 72110, 72114, 72120).

The RUC's 5-Year Review ID workgroup (since renamed the RUC Relativity Assessment workgroup) identified code 72110, Radiologic examination, spine, lumbosacral; minimum of 4 views, under its "**Harvard valued, utilization greater than 100,000**" screen for the February 2010 workgroup meeting. At the February 2010 meeting the societies submitted an action plan recommending maintenance of the current values for the family, based on their maintenance at the first 5 Year Review, and by crosswalk to other RUC-approved diagnostic X-Ray codes. This was the same methodology that was approved by the RUC for a series of lower extremity x-ray codes at the October 2009 meeting. The workgroup agreed that surveying low RVW codes with little time is difficult, however they were concerned with the apparently discrepant relationship between 72110, with a RVW of 0.31 and 6 minutes intra-time and 72120, Radiologic examination, spine, lumbosacral, bending views only, minimum of 4 views with a RVW of 0.22, also with 6 minutes.

At the April 2010 meeting of the 5-Year Review ID workgroup the societies presented a revised recommendation calling for the revision of the descriptors for 72120 and 72114 in order to clarify the progressive rank order relationships among codes 72100, 72110, 72114, and 72120. The workgroup agreed with this recommendation. The descriptors were revised at the October 2010 Editorial Panel meeting, and the societies have surveyed all four codes for this meeting.

Time and RVW recommendation

The societies surveyed code 72114 along with 72100, 72110, and 72120. The survey sample was a random sample from each participating society and we received a total of 48 survey responses. Subsequent to the compiling of the survey results, the societies convened an expert consensus panel to review the aggregated survey data and determine recommended RVW and recommended times.

Our survey median RVW was 0.32 with a total of 8 minutes. Our median times were 1 minute pre-time for day of evaluation, 5 minutes intra-time, and 2 minutes immediate post-time.

The most commonly chosen reference code was CPT code *74022, Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest* with a work RVU of 0.32 and 5 minutes total time (1 minute pre-service evaluation time, 3 minutes intra-time and 1 minute immediate post-service time). 74022 was surveyed in 2005 and has an IWPUT of 0.092.

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) 72114

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 Orthopaedics How often? Sometimes

Specialty Diagnostic Radiology How often? Sometimes

Specialty Neurosurgery How often? Sometimes

Estimate 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?

94,562 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.

Please explain the rationale for this estimate. 2009 Medicare Utilization

Specialty Orthopaedics	Frequency 39489	Percentage 41.75 %
------------------------	-----------------	--------------------

Specialty Diagnostic Radiology	Frequency 26440	Percentage 27.96 %
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Specialty Neurosurgery	Frequency 5239	Percentage 5.54 %
------------------------	----------------	-------------------

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 72114

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: 72120	Tracking Number	Original Specialty Recommended RVU: 0.22
		Presented Recommended RVU: 0.22
Global Period: XXX		RUC Recommended RVU: 0.22

CPT Descriptor: Radiologic Examination, spine, lumbosacral; bending views only, 2 or 3 views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Forty-five year old man with known Grade I spondylolisthesis from prior exams. Clinical concern for instability. Bending views ordered to evaluate for abnormal movement.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work:

Review clinical history

Review any prior applicable plain film or imaging studies

Description of Intra-Service Work:

Supervise technologist performing the examination.

Interpret radiographs of the lumbosacral spine.

Compare with prior studies, if applicable.

Dictate report.

Description of Post-Service Work:

Review and sign report.

Communicate findings to referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011				
Presenter(s):	William Creevy, MD; Zeke Silva, MD; Geraldine McGinty, MD; William Sullivan, MD; William Donovan, MD					
Specialty(s):	AAOS, ACR, ASNR, NASS					
CPT Code:	72120					
Sample Size:	500	Resp N:	48	Response: 9.6 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	2.00	3.00	5.00	15.00
Survey RVW:		0.16	0.22	0.27	0.32	0.51
Pre-Service Evaluation Time:				1.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		1.00	2.00	3.00	5.00	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			
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); 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:	72120	Recommended Physician Work RVU: 0.22		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		1.00	0.00	1.00
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:		3.00		
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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74020	XXX	0.27	RUC Time

CPT Descriptor Radiologic examination, abdomen; complete, including decubitus and/or erect views**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	14,267,661

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
	XXX		RUC Time	

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
71020	XXX	0.22	RUC Time

CPT Descriptor Radiologic examination, chest, 2 views, frontal and lateral;**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 18 % of respondents: 37.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 72120	<u>Key Reference CPT Code:</u> 74020	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	1.00	
Median Intra-Service Time	3.00	3.00	
Median Immediate Post-service Time	2.00	1.00	
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	6.00	5.00	
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	1.61	2.42
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.74	2.23
--	------	------

Urgency of medical decision making	2.38	2.21
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	2.36	1.65
--------------------------	------	------

Physical effort required	1.54	1.37
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.74	2.25
---	------	------

Outcome depends on the skill and judgment of physician	2.46	2.43
--	------	------

Estimated risk of malpractice suit with poor outcome	2.42	2.77
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.04	2.60
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Intra-Service intensity/complexity	2.15	2.60
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Post-Service intensity/complexity	2.19	2.57
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Additional Rationale and Comments

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

Background

72120, Radiologic Examination, spine, lumbosacral; bending views only, 2 or 3 views is presented for survey and review by the RUC as a part of a family of Spinal X-ray codes (72100, 72110, 72114, 72120).

The RUC's 5-Year Review ID workgroup (since renamed the RUC Relativity Assessment workgroup) identified code 72110, Radiologic examination, spine, lumbosacral; minimum of 4 views, under its **"Harvard valued, utilization greater than 100,000"** screen for the February 2010 workgroup meeting. At the February 2010 meeting the societies submitted an action plan recommending maintenance of the current values for the family, based on their maintenance at the first 5 Year Review, and by crosswalk to other RUC-approved diagnostic X-Ray codes. This was the same methodology that was approved by the RUC for a series of lower extremity x-ray codes at the October 2009 meeting. The workgroup agreed that surveying low RVW codes with little time is difficult, however they were concerned with the apparently discrepant relationship between 72110, with a RVW of 0.31 and 6 minutes intra-time and 72120, Radiologic examination, spine, lumbosacral, bending views only, minimum of 4 views with a RVW of 0.22, also with 6 minutes.

At the April 2010 meeting of the 5-Year Review ID workgroup the societies presented a revised recommendation calling for the revision of the descriptors for 72120 and 72114 in order to clarify the progressive rank order relationships among codes 72100, 72110, 72114, and 72120. The workgroup agreed with this recommendation. The descriptors were revised at the October 2010 Editorial Panel meeting, and the societies have surveyed all four codes for this meeting.

Time and RVW recommendation

The societies surveyed code 72120 along with 72100, 72110, and 72120. The survey sample was a random sample from each participating society and we received a total of 48 survey responses.

Our survey median RVW was 0.27 with a total of 6 minutes. The 25th % RVW was 0.22. Our median times were 1 minute pre-time for day of evaluation, 3 minutes intra-time, and 2 minutes immediate post-time.

The most commonly chosen reference code was CPT code 74022, *Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest* with a work RVU of 0.32 and 5 minutes total time (1 minute pre-service evaluation time, 3 minutes intra-time and 1 minute immediate post-service time). 74022 was surveyed in 2005 and has an IWP/PUT of 0.092.

We recommend maintaining the current RVW of 0.22 for 72120 which is also our survey 25% RVW. We are recommending a total of 6 minutes time which is the same as our total survey time and the same as the Harvard assigned times.

This procedure is typically performed in the lateral projection, with the patient performing flexion and extension maneuvers. This exam is typically requested in patients with chronic back pain for evaluation of a known or suspected listhesis. The societies feel there is slightly greater work required in evaluation of the spine itself on this exam than on the 72100 procedure (frontal and lateral projections); however, there is more anatomy outside the spine revealed on the 72100 (frontal and lateral) exam, as well as the need to evaluate the spine in two projections; and the societies and their surveyees agree that these exams are essentially equivalent in terms of physician work.

Below is a table showing the four codes surveyed, their minimum number of views, total recommended times, current (Harvard) total times, Recommended work RVUs, Current (Harvard) work RVUs, the recommended IWP/PUTs and the current IWP/PUTs.

CPT Code	Bending or Non-Bending	Minimum Number of Views	Recommended Total Time	Current (Harvard) Total Time	Recommended Work RVU	Current (Harvard) Work RVU	Recommended IWP/PUT	Current IWP/PUT
72100	Non-bending	2 or 3	6	6	0.22	0.22	0.044	0.037

						CPT Code: 72120			
72120	Bending	2 or 3	6	6	0.22	0.22	0.044	0.037	
72110	Non-Bending	4	8	6	0.31	0.31	0.044	0.052	
72114	Bending	6	8	6	0.36	0.36	0.053	0.060	

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) 72120

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 Orthopaedics How often? Sometimes

Specialty Orthopaedics How often? Sometimes

Specialty Neurosurgery How often? Rarely

Estimate 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? 25,801 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2009 Medicare Utilization

Specialty Orthopaedics	Frequency 14936	Percentage 57.88 %
Specialty Diagnostic Radiology	Frequency 3906	Percentage 15.13 %
Specialty Neurosurgery	Frequency 2371	Percentage 9.18 %

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 72120

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 Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs**

CPT Long Descriptor:

72100, Radiologic examination, spine, lumbosacral; 2 or 3 views

72110, Radiologic examination, spine, lumbosacral; minimum of 4 views

72114, Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views

72120, Radiologic Examination, spine, lumbosacral; bending views only, 2 or 3 views

Global Period:XXX

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

A consensus panel of experts representing orthopaedic surgery, radiology, spine surgery, and neuroradiology reviewed the practice expense details for 72100, 72110, 72114, 72120. We maintained the same PE inputs assigned to each respective code under the PEAC with the exception of 72120. For 72120 we reduced some PE inputs because the number of views in the descriptor changed from 4 to 2 or 3.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

None for all four codes.

Intra-Service Clinical Labor Activities:

Code 72100

We assigned 20 minutes total clinical labor intra-service time. 20 minutes is the total intra-service clinical labor service time for 72100 currently and we believe continues to be the correct amount of intra-service clinical labor service time. Each of the inputs is the same as in the current PE files for 72100. The 20 minutes are broken out as follows.

Service Period Pre-Service

3 minutes (line 18) for greeting the patient and gowning the patient.

1 minute (line 20) for preparing and positioning of the patient.

Service Period Intra-Service

CPT Code: 72100, 72110, 72114, 72120
Specialty Society('s)_ AAOS, ACR, NASS, ASNR_

9 minutes (line 24) for acquiring of images by the radiologic tech.

Service Period Post-Service

2 minutes (line 26) for cleaning the room and equipment.

4 minutes (line 28) for processing films, hanging films and reviewing study with interpreting MD prior to patient discharge.

Code 72110

We assigned 28 minutes total clinical labor intra-service time. 28 minutes is the total intra-service clinical labor service time for 72110 currently and we believe continues to be the correct amount of intra-service clinical labor service time. Each of the inputs is the same as in the current PE files for 72110. The 28 minutes are broken out as follows.

Service Period Pre-Service

3 minutes (line 18) for greeting the patient and gowning the patient.

1 minute (line 20) for preparing and positioning of the patient.

Service Period Intra-Service

15 minutes (line 24) for acquiring of images by the radiologic tech.

Service Period Post-Service

2 minutes (line 26) for cleaning the room and equipment.

6 minutes (line 28) for processing films, hanging films and reviewing study with interpreting MD prior to patient discharge.

Code 72114

We assigned 36 minutes total clinical labor intra-service time. 36 minutes is the total intra-service clinical labor service time for 72114 currently and we believe continues to be the correct amount of intra-service clinical labor service time. Each of the inputs is the same as in the current PE files for 72114. The 36 minutes are broken out as follows.

Service Period Pre-Service

3 minutes (line 18) for greeting the patient and gowning the patient.

1 minute (line 20) for preparing and positioning of the patient.

Service Period Intra-Service

21 minutes (line 24) for acquiring of images by the radiologic tech.

Service Period Post-Service

2 minutes (line 26) for cleaning the room and equipment.

8 minutes (line 28) for processing films, hanging films and reviewing study with interpreting MD prior to patient discharge.

CPT Code: 72100, 72110, 72114, 72120
Specialty Society('s)_ AAOS, ACR, NASS, ASNR_

Code 72120

We assigned 22 minutes total clinical labor intra-service time. 22 minutes two fewer minutes than is currently assigned to the total intra-service clinical labor service time for 72120. We believe this reduction is appropriate because the number of views described by code 72120 changed from 4 (previous) to 2 or 3 (new). The 22 minutes are broken out as follows.

Service Period Pre-Service

3 minutes (line 18) for greeting the patient and gowning the patient.

1 minute (line 20) for preparing and positioning of the patient.

Service Period Intra-Service

11 minutes (line 24) for acquiring of images by the radiologic tech. This is one minute less than the current radiologic tech time which we believe is appropriate based on the fact the number of images to obtain has been reduced by 1.

Service Period Post-Service

2 minutes (line 26) for cleaning the room and equipment.

4 minutes (line 28) for processing films, hanging films and reviewing study with interpreting MD prior to patient discharge. This is one minute less than the film processing time which we believe is appropriate based on the fact the number of images to obtain has been reduced by 1.

Post-Service Clinical Labor Activities:

None for all four codes

	A	B	C	D	E	F
1	Spine Xray Code Revisions		72100	72110	72114	72120
2	AMA/Specialty Society RVS Update Committee Recommendation		Radiologic examination, spine, lumbosacral; 2 or 3 views	Radiologic examination, spine, lumbosacral; minimum of 4 views	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views	Radiologic examination, spine, lumbosacral, bending views only, 2 or 3 views
		CMS Code				
3	Tab 9		NonFac	NonFac	NonFac	NonFac
4	Feb-11		XXX	XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME		20	28	36	23
6	TOTAL PRE-SERV CLINICAL LABOR TIME					
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		20	28	36	23
8	TOTAL POST-SERV CLINICAL LABOR TIME					
9	PRE-SERVICE PERIOD					
10	Start: Following visit when decision for surgery or procedure made					
11	Other Clinical Activity (please specify)					
12	<i>- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information</i>					
13	End: When patient enters office/facility for surgery/procedure					
14	SERVICE PERIOD					
15	Start: When patient enters office/facility for surgery/procedure					
16	Pre-service					
17	Greet patient and provide gowning		3	3	3	
18	Provide pre-service education/obtain consent					
19	Prepare room, equipment, supplies/ <i>Enter patient demographic information into scanner</i>		1	1	1	2
20	Prepare and position patient		1	1	1	2
21	Intra-service					
22	Assist physician in performing procedure					
23	<i>- Acquire Images</i>					
24	<i>- Acquire Images</i>	L041B	9	15	21	11
25	Post-Service					
26	Clean room/equipment by physician staff		2	2	2	1
27	Other Clinical Activity: follow up phone call					
28	<i>- Process films, hang films and review study with interpreting MD prior to patient discharge</i>		4	6	8	4
29	End: Patient leaves office					
30	POST-SERVICE PERIOD					
31	MEDICAL SUPPLIES					
32	Film x-ray 10"x 12"	SK033	1	1	1	
33	Film, 14"x17"	SK044	2	4	6	3
34	Xray developer solution	SK089	3	5	7	3

AMA/Specialty Society RVS Update Committee Recommendation

	A	B	C	D	E	F
1	Spine Xray Code Revisions		72100	72110	72114	72120
2	AMA/Specialty Society RVS Update Committee Recommendation	CMS Code	Radiologic examination, spine, lumbosacral; 2 or 3 views	Radiologic examination, spine, lumbosacral; minimum of 4 views	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views	Radiologic examination, spine, lumbosacral, bending views only, 2 or 3 views
3	Tab 9		NonFac	NonFac	NonFac	NonFac
4	Feb-11		XXX	XXX	XXX	XXX
35	Xray fixer solution	SK092	3	5	7	3
36	Patient gown, disposable	SB026	1	1	1	
37	Equipment					
38	Room Basic Radiology	EL012	17	25	33	20
39	Film alternator, wet	ED025	17	28	36	23
40	Laser printer	ED032	10	10	10	10
41						

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Identified through the High Volume Growth, CMS Fastest Growing, Codes Reported Together 75% or More Screens

February 2011

CTA Abdomen and Pelvis

In April 2010, CPT code 74175 *Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 1.90) and 72191 *Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 1.81) were identified by the Relativity Assessment Workgroup's Codes Reported Together 75% or More Screen, with both services reported together over 95% of the time together. The American College of Radiology (ACR) submitted an Action Plan that stated they would submit a code change proposal that bundles the work of the two services when reported together. In October 2010, the CPT Editorial Panel created CPT code 74174 which bundles the work of 74175 and 72191 when reported together on the same date of service.

74174 Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing

The RUC reviewed the specialty survey results from 42 radiologists for CPT code 74174. The RUC recommends pre-service time of 5 minutes, intra-service time of 30 minutes, and post service time of 5 minutes. The RUC analyzed the survey's estimated physician work and time. The RUC agreed that these data support the survey's 25th percentile estimated work value of 2.20 work RVUs. The RUC noted that this value, 2.20 work RVUs, is a 69% decrease from the current reporting of these services, 74175 (work RVU= 1.90) + 72191 (work RVU= 1.81)= 3.71 work RVUs. To further justify this recommended value, the RUC compared the surveyed code to key reference service CPT code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU= 2.40, intra-time= 45 minutes). The RUC noted that 75635 includes CTA of 3 body regions (the abdomen, pelvis and lower extremities) while 74174 only includes 2 of these regions (the abdomen and pelvis). The difference in the number of regions explains the intra-service time differences of 45 minutes for the reference code and 30 minutes for the surveyed code and justifies a higher work RVU for the reference code.

In addition, the RUC compared CPT code 74174 to the recently RUC reviewed 74178 *Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions* (work RVU= 2.01 and intra-time= 30 minutes). Both 74178 and 74174 involve the study of the abdomen and pelvis with and without the administration of IV contrast. However, the surveyed code requires the processing, review and reporting of 3-D data, which is captured by the work of 76377 *3D rendering with interpretation and reporting of computed tomography, etc* (work RVU= 0.79). Adding the work RVUs of 74178 and 76377 yields a work RVU of 2.80, which is greater than the survey data supports. Thus, the RUC agreed that a work RVU of 2.20 for 74174 maintains proper rank order. Finally, the RUC noted that although the 30 minutes of intra-service time is comparable between the surveyed code and base codes 72191 and 74175, the intensity of interpreting 2 body regions and the concordant increase in the number of images and potential pathology warrants a higher work value. Given these comparisons, the RUC agreed that the survey's 25th percentile work RVU of 2.20 maintains appropriate rank order across the family of services and is an accurate depiction of the physician work involved in the service. **The RUC recommends a work RVU of 2.20 for CPT code 74174.**

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.

Practice Expense:

The RUC reviewed the direct inputs presented, made one edit to the equipment, and accepted the recommendation as presented.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
72191		Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	XXX	1.81 (No Change)
● 74174	II	Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing <u>(Do not report 74174 in conjunction with 72191, 73706, 74175, 75635, 76376, 76377)</u> <u>(For CTA aorto-iliofemoral runoff, use 75635)</u>	XXX	2.20

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
74175		Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing	XXX	1.90 (No Change)

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

CPT Code:74174 Tracking Number II

Original Specialty Recommended RVU: **2.20**Presented Recommended RVU: **2.20**

Global Period: XXX

RUC Recommended RVU: **2.20**

CPT Descriptor: Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old male who has had a 6 cm abdominal aortic aneurysm detected on routine screening ultrasound. He is undergoing computed tomographic angiography of the abdomen and pelvis for pre-operative evaluation prior to aortic endograft placement.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 1%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history including history of contrast allergy, renal insufficiency or other contraindication to IV contrast
- Review any prior imaging studies
- Determine the appropriate CT protocol for the examination, confirm that pre- and post-contrast images are indicated, and communicate that protocol to the CT technologists

Description of Intra-Service Work:

- Supervise insertion of IV catheter, selection of contrast media, and set-up of mechanical injector
- Supervise acquisition of scout views, prescribe area to be scanned and supervise acquisition of unenhanced axial CT image data
- Review the initial unenhanced series of CT image data to assure adequacy of anatomic coverage and assess need for additional sections, additional delayed images or reconstruction of thin sections in specific locations
- Supervise use of mechanical power injector for administration of a rapid (4-7 mL/sec) bolus of intravenous contrast during test-bolus or computer-assisted bolus tracking, and select optimal contrast delay that will result in peak contrast enhancement of major vessels
- Supervise scanning for acquisition of axial source image sections in multiple phases of contrast enhancement

- Supervise monitoring for contrast reaction or contrast extravasation during injection
- Review the arterial and delayed phases of CT image data to assure adequacy of anatomic coverage and assess need for additional sections, additional delayed images or reconstruction of thin sections in specific locations
- Supervise reconstruction of coronal and/or sagittal 2-D multiplanar reformatted (MPR) and 3-D (such as volume rendering, maximum intensity projection (MIP)) images in multiple projections/views on scanner console or free-standing work-station, and assess need for oblique or other 2-D or 3-D images
- Review and interpret scout radiographs, all source images, additional sections, multiplanar reformations, and 3-D images - typically 800 images are acquired which increases to 1800 images when reviewed with the various requisite window/level settings
- Axial and multiplanar reformatted images are interpreted in arterial phase and delayed phases using "soft-tissue windows" to provide detailed evaluation of each of the following organs: lower mediastinum, liver, spleen, gallbladder, adrenal glands, kidneys, ureters, bladder, retroperitoneal soft-tissues, stomach, duodenum, small bowel, appendix, colon, pelvic genito-urinary/reproductive organs, all lymph node chains, major abdominal arterial and venous vasculature, and supporting musculature
- Axial and 2-D reformatted images are interpreted using "vascular" windows to assess vessel contour and detect thrombus, "bone windows" to assess the skeletal structures, "liver windows" to assess the liver and "lung windows" to assess the lung base visualized on the scan
- 3-D volume rendered and/or MIP images are interpreted
- Perform measurements for selection of appropriate endovascular graft
- Compare current findings 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)	02/2011				
Presenter(s):	Geraldine McGinty MD, Zeke Silva MD				
Specialty(s):	The American College of Radiology				
CPT Code:	74174				
Sample Size:	157	Resp N:	42	Response: 26.7 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		10.00	30.00	100.00	193.75
Survey RVW:		1.98	2.20	2.40	2.90
Pre-Service Evaluation Time:				5.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		10.00	20.00	30.00	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 0.00	99239x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 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); 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:	74174	Recommended Physician Work RVU: 2.20		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	7.00	-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:		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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
75635	XXX	2.40	RUC Time

CPT Descriptor Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
13133	ZZZ	2.19	RUC Time	9,661

CPT Descriptor 1 Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11443	010	2.34	RUC Time	15,479

CPT Descriptor 2 Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 50.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 74174	<u>Key Reference CPT Code:</u> 75635	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	10.50	
Median Intra-Service Time	30.00	45.00	
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	40.00	70.50
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	3.95	3.90
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.60
--	------	------

Urgency of medical decision making	3.90	3.80
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.10	4.10
--------------------------	------	------

Physical effort required	2.62	2.90
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.48	3.30
---	------	------

Outcome depends on the skill and judgment of physician	4.10	4.25
--	------	------

Estimated risk of malpractice suit with poor outcome	3.76	3.65
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.40	2.42
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Intra-Service intensity/complexity	4.00	4.16
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Post-Service intensity/complexity	2.95	3.06
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Additional Rationale and Comments

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

The ACR convened a panel that included a number of experts familiar with this service to evaluate the RUC survey data. CPT codes 74175 (Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing) and 72191 (Computed tomographic angiography,

pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing) were identified by the Relativity Assessment Workgroup (formerly the Five Year Review Workgroup) as potentially misvalued based on the 75% frequency with which they are reported together. CTA of the abdomen (74175) and pelvis (72191) when performed together will now be reported as the surveyed code 74174.

Recommendations:

We are recommending the 25% RVU of 2.2, pre-service package 5 (minus 2 minutes) and the median intra and post service times of 30 and 5 minutes, respectively.

Change to Pre-Service Time:

Our panel recommends pre-service package 5 (procedure without sedation/anesthesia care) which has a total pre-service time of 7 minutes. However, we recommend subtracting 2 minutes from the total pre-service time consistent with our survey results.

Comparison to the Key Reference Services:

The key reference service 75635 (Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing) was chosen by the majority of our survey respondents and compares favorably with our surveyed code. 75635 includes CTA of 3 body regions (the abdomen, pelvis and lower extremities) while our surveyed code only includes 2 of these regions (the abdomen and pelvis). The RVU value recommended by our panel falls appropriately between the value of the single body regions, CTA abdomen with contrast (RVU 1.90) or CTA Pelvis with contrast (RVU 1.81) and the 3 body region CTA run-off 75635 (RVU 2.4). Further, our RVU recommendation is supported by the intra-service time for our surveyed code being less than the 45 minutes of intra-service time required for a full CTA run-off. We recognize that the time elements for the surveyed code shows similar intraservice time as the single body region code; however, based on appropriate rank order and differences in intensity the modest increase in RVUs above the single body region code is justified.

74178 (Computed tomography abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast materials and further sections in one or both body regions-RVU-2.1) is a recently RUC surveyed code and was the second most commonly chosen reference service. It also compares favorably with our surveyed code. Both 74178 and 74174 involve the study of the abdomen and pelvis with and without the administration of IV contrast. Our surveyed code, however, requires the processing, review and reporting of 3-D data, which is captured by the work of 76377 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation). 76377 has a work RVU of .79 and 17 minutes of intra-service time. Thus, adding the RVUs of 74178 (2.01) and 76377 (.79) yields 2.8 RVUs which our panel felt was greater than the survey data supported. Our recommended RVUw of 2.2 maintains relativity between these services.

Comparison to codes on the MPC list:

Our recommendation compares favorably to 2 codes on the MPC list each of which have the same intra-service time of 30 minutes and RVUs which bracket our recommendation of 2.2 RVU. These MPC codes are 13133 (Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (List separately in addition to code for primary procedure) with 2.19 RVUs and 11443 (Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm) with 2.34.

Comparison to other codes in the CTA family:

Our recommendations maintain relativity with the rest of the CTA family as summarized in the chart below (descriptors shortened). Our surveyed code includes the base codes 74175 and 72191 and we must acknowledge some efficiency is gained when interpreting these body regions together. However, to maintain proper rank within the family, our surveyed code should fall between the CTA abdomen code (74175 - 1.9 RVU) and the CTA run-off (75635 – 2.4 RVU). Our 25th percentile recommendation of 2.2 maintains appropriate rank order.

Even though the 30 minutes of intra-time is comparable, the intensity of interpreting 2 body regions and the concordant increase in the number of images and potential pathology warrants the higher RVU.

CPT code	Work RVU	Preservice time	Intraservice time	Postservice time	Total time	CPT Descriptor
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70496	1.75	8	20	10	38	CTA head
70498	1.75	7	20	10	37	CTA Neck
72191	1.81	9	30	10	49	CTA pelvis
73206	1.81	10	30	10	50	CTA upper extremity
74175	1.9	10	30	10	50	CTA abdomen
73706	1.9	10	30	10	50	CTA lower extremity
71275	1.92	9.5	30	10	49.5	CTA chest
74174	2.2	5	30	5	40	CTA abdomen and pelvis
75635	2.4	10.5	45	15	70.5	CTA run-off
75574	2.4	10	30	10	50	CTA heart

Summary:

In summary, our survey supports our recommendation of 2.2 work RVUs, pre-service package 5 minus 2 minutes, and the median intra and post service times of 30 and 5 minutes, respectively. These recommendations compare favorably to our #1 and #2 most chosen reference services as well as 2 codes on the MPC list.

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) 72191, 74175

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? 836073

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 7417XX in one year period is estimated to be 836073

Specialty Diagnostic Radiology	Frequency 493283	Percentage 58.99 %
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Specialty	Frequency 0	Percentage 0.00 %
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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?
 107,215 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. 95% of the Medicare Utilization for 72191 (112,858)

Specialty Diagnostic Radiology	Frequency 63257	Percentage 59.00 %
--------------------------------	-----------------	--------------------

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

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. 74175

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

CPT Long Descriptor:

Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing

(Do not report 74174 in conjunction with 72191, 73706, 74175, 75635, 76376, 76377)

(For CTA aorto-iliofemoral runoff, use 75635)

Global Period: XXX

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

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

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

The ACR used 74178 (Computed tomography abdomen and pelvis; without contrast material in one or both body regions, followed by with contrast materials and further sections in one or both body regions) and 76377 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation) as comparison codes. Code 74178 is a recently RUC surveyed code, was the second most commonly chosen reference service and the practice expense inputs also compares favorably with our surveyed code. Both codes involve the study of the abdomen and pelvis with and without the administration of IV contrast.

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
- Greet patient and provide gowning
- Education/instruction/counseling/obtain consent
- Prepare room, equipment, supplies
- Prepare and position patient/ monitor patient/ set up IV
- Perform CT examination to obtain source images

Intra-Service Clinical Labor Activities:

- Assist physician in performing procedure/Computer post processing
- Acquire images

Post-Service Clinical Labor Activities:

- Clean room/equipment
- Starting IV for high volume and rate power injection
- Process films, hang films and review study with interpreting MD prior to patient discharge

	A	B	C	D
1	Feb-11			74174
2	AMA/Specialty Society RVS Update Commitee Recommendation	CMS Code	STAFF	Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing
3	LOCATION			NonFac
4	GLOBAL PERIOD			XXX
5	TOTAL CLINICAL LABOR TIME		RT	128
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L041B	RT	7
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		RT	121
8	PRE-SERVICE PERIOD			
9	Start: Following visit when decision for surgery or procedure made			
11	- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information	L041B	RT	7
12	End: When patient enters office/facility for surgery/procedure			
13	SERVICE PERIOD			
14	Start: When patient enters office/facility for surgery/procedure			
15	Pre-service			
16	Greet patient and provide gowning	L041B	RT	3
17	Education/instruction/counseling/obtain consent	L041B	RT	3
18	Prepare room, equipment, supplies	L041B	RT	4
19	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	5
21	Intra-service			
22	Assist physician in performing procedure/Computer post processing	L046A	RT	33
23	Acquire images	L041B	RT	45
24	Post-Service			
25	Clean room/equipment	L041B	RT	3
27	Other Clinical Activity: Process films, hang films and review study with interpreting MD prior to patient discharge	L046A	RT	25
28	End: Patient leaves office			
29	MEDICAL SUPPLIES			
30	Alcohol Swab	SJ053		1
31	Angiocatheter	SC002		1
32	Band aid	SG021		1
33	Betadine Swab	SJ043		1
34	CD	SK016		1
35	Drape, Sheet	SB014		1
36	Extension Tubing	SC019		1
37	Film, 14x17 (sheets)	SK034		8
38	Film, 14x17, laser (surrogate for digital archival)	SK098		23
39	Film jacket	73405		1
40	Film developer/cost per exposure	SK089		8
41	Film fixer	SK092		8
42	Gauze 2x2	SG053		1
43	Gauze 2x2, nonsterile	SG050		1
44	Gloves, sterile (pair)	SB022		1
45	Heplock	SC012		1
46	IV start kit	SA019		1
47	Needle, 20G	SC025		1
48	Patient gown, disposable	SB026		1
49	Saline (cc)	SH065		15
50	Syringe, 20cc	SC053		1
51	Table paper (ft)	SB036		7
52	Tape (inch)	SG075		6
53	Tube, connecting	SD260		1
54	Tube, extension (cm)	SC019		76
55	Equipment			
56	3D reconstruction workstation	ED014		38
57	CT Room	EL007		82
58	Film alternator	ER029		82
59	Film processor	ED024		82
60	Printer, laser	ED032		10

	A	B	C	D
1	Feb-11			74174
2	AMA/Specialty Society RVS Update Commitee Recommendation		STAFF	Computed tomographic angiography, abdomen and pelvis; with contrast material(s), including noncontrast images, if performed, and image postprocessing
		CMS Code		
3	LOCATION			NonFac
4	GLOBAL PERIOD			XXX
5	TOTAL CLINICAL LABOR TIME		RT	127
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L041B	RT	7
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME		RT	120
8	PRE-SERVICE PERIOD			
9	Start: Following visit when decision for surgery or procedure made			
11	- Retrieve prior appropriate imaging exams and hang for MD review, verify orders, review the chart to incorporate relevant clinical information	L041B	RT	7
12	End: When patient enters office/facility for surgery/procedure			
13	SERVICE PERIOD			
14	Start: When patient enters office/facility for surgery/procedure			
15	Pre-service			
16	Greet patient and provide gowning	L041B	RT	3
17	Education/instruction/counseling/obtain consent	L041B	RT	2
18	Prepare room, equipment, supplies	L041B	RT	4
19	Prepare and position patient/ monitor patient/ set up IV	L041B	RT	5
21	Intra-service			
22	Assist physician in performing procedure/Computer post processing	L046A	RT	33
23	Acquire images	L041B	RT	45
24	Post-Service			
25	Clean room/equipment	L041B	RT	3
27	Other Clinical Activity: Process films, hang films and review study with interpreting MD prior to patient discharge	L046A	RT	25
28	End: Patient leaves office			
29	MEDICAL SUPPLIES			
30	Alcohol Swab	SJ053		1
31	Angiocatheter	SC002		1
32	Band aid	SG021		1
33	Betadine Swab	SJ043		1
34	CD	SK016		1
35	Drape, Sheet	SB014		1
36	Extension Tubing	SC019		3
37	Film, 14x17 (sheets)	SK034		8
38	Film, 14x17, laser (surrogate for digital archival)	SK098		23
39	Film jacket	73405		0
40	Film developer/cost per exposure	SK089		8
41	Film fixer	SK092		8
42	Gauze 2x2	SG053		1
43	Gauze 2x2, nonsterile	SG050		1
44	Gloves, sterile (pair)	SB022		1
45	Heplock	SC012		1
46	IV start kit	SA019		1
47	Needle, 20G	SC025		0
48	Needle, 18-27G	SC029		1
49	Patient gown, disposable	SB026		1
50	Saline (cc)	SH065		15
51	Syringe, 20cc	SC053		0
52	Table paper (ft)	SB036		7
53	Tape (inch)	SG075		6
54	Tube, connecting	SD260		0
55	Tube, extension (cm)			76
56	stop-cock, 4-way	SC050		1
57	Syringe, pressure	SC060		1
58	tubing, sterile, connecting	SD212		1
59	Equipment			
60	3D reconstruction workstation	ED014		20
61	CT Room	EL007		57
62	Film alternator	ER029		20
63	Film processor	ED024		20
64	Printer, laser	ED032		10

AMA/Specialty Society RVS Update Committee Summary of Recommendations

February 2011

Intraoperative Radiation Treatment Delivery and Management

In October 2010, the CPT Editorial Panel created three new codes and revised one code to describe the intraoperative radiation treatment management as the current radiation treatment management code does not describe or include the work required when performed intraoperatively.

The RUC reviewed the survey results of 45 radiation oncologists for CPT code 77469 *Intraoperative radiation treatment management* and determined that the survey 25th percentile work RVU of 5.75 appropriately accounts for the physician work required to perform this service. The RUC recommended a modification to the pre service time package selection from difficult patient/difficult procedure to pre service package 3 straightforward patient/difficult procedure, ultimately recommending 51 minutes of pre service time. The RUC agreed with the remaining specialty society survey times, intra-service of 90 minutes and post-service time of 30 minutes. The specialty society specifically described the intra-service time required by the radiation oncologist which includes selecting the intra-operative cone most suitable for the field in question, placing the cone in position, ensuring the radiation field covers the area in question, fabricating additional shielding and placing it into the intra-operative wound, adding bolus if necessary, locking cone into position over the wound, checking angles, and moving the whole apparatus, operating table, cone, and patient to align to the radiation machine. Once the apparatus is set the physician leaves the room and delivers radiation to the patient. The RUC agreed that the intra-service time of 90 minutes appropriately accounts for the physician work required. The RUC compared code 77469 to the reference code 77470 *Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)* (work RVU = 2.09). The RUC noted that the surveyed code has significantly more intra-service time as compared to the reference code, 90 minutes and 55 minutes, respectively. Further, the RUC noted that the survey respondents indicated that the surveyed code requires more mental effort and judgment, technical skill, physical effort and overall is a more intense service to perform in comparison to the reference code. To further support the survey 25th percentile, the RUC compared the surveyed code to similar services 20555 *Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)* (work RVU = 6.00 and intra-service time = 70 minutes) and 77787 *Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels* (work RVU = 4.89 and intra-service time = 90 minutes). Based on magnitude estimation compared to these similar services, the RUC determined the survey 25th percentile work RVU of 5.75 appropriately aligns the surveyed service with other similar services in the RBRVS. **The RUC recommends the survey 25th percentile work RVU of 5.75 for CPT code 77469.**

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.

Practice Expense:

The Practice Expense Subcommittee reviewed the recommended direct inputs from the specialty society in detail and made a slight reduction in the clinical labor time in the facility setting. This procedure is performed in the facility only and no direct practice expense inputs are recommended.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●77424	J1	Intraoperative radiation treatment delivery, x-ray, single treatment session	XXX	0.00 (Facility Only)
●77425	J2	Intraoperative radiation treatment delivery, electrons, single treatment session	XXX	0.00 (Facility Only)
<p>Radiation Treatment Management</p> <p>Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time period in which the services are furnished. The services need not be furnished on consecutive days. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted separately as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately. Radiation treatment management requires and includes a minimum of one examination of the patient by the physician for medical evaluation and management (eg, assessment of the patient’s response to treatment, coordination of care and treatment, review of imaging and/or lab test results with documentation) for each reporting of the radiation treatment management service. <u>77469 represents only the intraoperative session management and does not include medical evaluation and management outside of the session.</u> The professional services furnished during treatment management typically include:</p> <ul style="list-style-type: none"> ▪ Review of port films; ▪ Review of dosimetry, dose delivery, and treatment parameters; ▪ Review of patient treatment set-up. 				
●77469	J3	Intraoperative radiation treatment management	XXX	5.75
▲77470	J4	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral; or <u>endocavitary</u> or intraoperative cone irradiation)	XXX	2.09 (No Change)

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(For intraoperative radiation treatment delivery and management, see 77424-77469)		

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

CPT Code: 77469 Tracking Number JJ3 Original Specialty Recommended RVU: **8.00**
 Presented Recommended RVU: **8.00**
 Global Period: XXX RUC Recommended RVU: **5.75**

CPT Descriptor: Intraoperative radiation treatment management

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old man with a history of alcohol and tobacco abuse presents with a squamous cell cancer of the tongue with involved cervical lymph nodes. He receives combined modality chemotherapy and radiation with complete regression of tumor. Sixteen months later recurrent neck node is detected. PET/CT shows no other disease. Following resection of the recurrence via radical neck dissection, intraoperative radiation is delivered to the tumor bed.

Percentage of Survey Respondents who found Vignette to be Typical: 58%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 33%

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? 11%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review imaging studies and prior radiation records for tissue tolerance and identification of organs at risk
- Review planned resection with surgeon
- Review anticipated radiation needs with physicist (who will perform specific output testing and ensure adequate shielding and bolus availability).
- With the surgeon, position patient to ensure eventual IORT field will be within constraints of equipment
- Scrub in again after primary surgery and reposition patient as necessary to ensure access

Description of Intra-Service Work:

- Review operative specimen with surgeon
- Review margins with pathologist to determine target areas, depth of penetration required, energy, etc.
- Review surgical field with surgeon for tumor areas and normal structures
- Applicator selected for appropriate size and shape. The cone is manipulated into position. Position of the cone over the target must be assured and all normal structures in the field or deep to the field must be identified.
- With applicator in position, the angle of incidence is measured with radiation device specific level (to ensure that the angle does not exceed the design specifications of the radiation machine) and adjusted as indicated
- At the discretion of the RO a surface bolus may be attached to the applicator to maximize surface dose
- In-field lead shielding is selected, cut, or fashioned to meet needs and shielding is placed.

- Applicator is positioned and held in place with a modified Bookwalter retractor system
- RO makes certain all important structures have been retracted out from the radiation field
- Suction is used to keep the target area as dry as possible (fluid will alter the depth of the penetration of the radiation beam). Wet gauze is placed over exposed tissues that are not in field.
- Accelerator is set up for treatment
- Operative table is unlocked and the team collaborates to move the table and patient into position under the accelerator
- Final position placement achieved
- Table is Relocked
- Geometric alignment of the applicator with the gantry head of the accelerator is achieved with a laser alignment system. This soft docking alignment is verified through respiratory cycle.
- Once this is completed the team moves to the sub sterile room. Radiation Oncologist remains in gown and gloves to be able to adjust device as needed.
- The prescribed radiation dose is administered
- Treatment dose is interrupted instantaneously if the patient experiences a problem and the physicians must re-enter the room. (This is common from either machine faults, respiratory movements causing misalignment, etc.)
- The docking of the radiation device is reversed and the machine backed away from the patient without trauma to the area.
- Team returns operative table under the surgical lights
- After the proper positioning of the applicator is reconfirmed, the applicator is removed. All bolus and shielding is removed.

Description of Post-Service Work:

- Verbal radiation prescription is written in record.
- Dictation
- Discuss future plans with other physicians
- Meet with family

SURVEY DATA

RUC Meeting Date (mm/yyyy)		02/2011			
Presenter(s):	David Beyer, MD; Michael Kuettel, MD, PhD; Najeeb Mohideen, MD; Gerald White, MS				
Specialty(s):	American Society for Radiation Oncology (ASTRO)				
CPT Code:	77469				
Sample Size:	173	Resp N:	45	Response: 26.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	0.00	3.00	10.00
Survey RVW:		2.10	5.75	8.00	8.80
Pre-Service Evaluation Time:				60.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		30.00	60.00	90.00	110.00
Immediate Post Service-Time:	30.00				
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		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 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); 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:	77469	Recommended Physician Work RVU: 8.00		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		33.00	33.00	0.00
Pre-Service Positioning Time:		3.00	3.00	0.00
Pre-Service Scrub, Dress, Wait Time:		15.00	15.00	0.00
Intra-Service Time:		90.00		
Immediate Post Service-Time:	30.00			
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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
77470	XXX	2.09	RUC Time

CPT Descriptor Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral, endocavitary or intraoperative cone irradiation)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
<u>CPT Descriptor 1</u>				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
<u>CPT Descriptor 2</u>		0.00		

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
41019	000	8.84	RUC Time

CPT Descriptor Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 35.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 77469	<u>Key Reference CPT Code:</u> 77470	<u>Source of Time RUC Time</u>
Median Pre-Service Time	51.00	0.00	
Median Intra-Service Time	90.00	55.00	
Median Immediate Post-service Time	30.00	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	171.00	55.00	

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	3.81
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.06	3.94
--	------	------

Urgency of medical decision making	3.94	3.69
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.94	3.88
--------------------------	------	------

Physical effort required	3.69	3.31
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.94	3.81
---	------	------

Outcome depends on the skill and judgment of physician	4.00	3.81
--	------	------

Estimated risk of malpractice suit with poor outcome	3.88	3.38
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.81	3.69
----------------------------------	------	------

Intra-Service intensity/complexity	4.00	3.69
------------------------------------	------	------

Post-Service intensity/complexity	2.88	2.88
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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 code 77469 *Intraoperative radiation treatment management* was approved at the October 2010 CPT Editorial Panel meeting. The code describes the physician work of intraoperative radiation treatment (IORT) management. It has been assigned an XXX global period and is typically performed in the facility setting.

ASTRO conducted a survey and collected 45 surveys. ASTRO convened a panel that included experts familiar with this service to evaluate the RUC survey data.

Service Performance Rate

There were several surveys received with a service performance rate of zero. The survey data results did not result in a median service performance rate of zero, so we did not present the survey data to the RUC with separate summary of recommendation forms summarizing the data for those who have performed the service, those who have not performed the service and the aggregate data. However, the expert panel did review the three sets of data (SPR = 0, SPR >0 and aggregate data) and found the survey data to be analogous (i.e. time and RVU recommendations).

The expert panel discussed the possible reasons for having several surveys with a service performance rate of zero. Experts in the field explained that several providers who have experience with IORT may not have performed this service in the last *12 months*. Radiation oncologists are trained for IORT however they may be in a practice that does not currently offer it to patients.

Vignette

The median percentage of survey respondents who found the vignette to be typical was 58%. It is important to note that in the explanations for why survey respondents indicated “no” to this question was that although the vignette described was appropriate and/or typical they personally more often performed other types of IORT (i.e. retroperitoneal, rectal, pelvis, gyn, GI, breast or abdomen).

Survey Time & Changes to Pre-Service Time

The total survey time was 180 minutes. The median pre time was 60 minutes, median intra time was 90 minutes and median post time was 30 minutes. ASTRO is recommending the median survey times for pre, intra and post. We are recommending a pre service package 4 (*Difficult Patient/Difficult Procedure*) with one adjustment, deleting 3 minutes of evaluation time in order to maintain the median pre time (as not to increase the survey time by 3 minutes). The expert panel reviewed the various pre service packages and concluded that pre service time package 4 was most appropriate.

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. Basic radiation dosimetry calculations may be required (CPT Code 77300). XXX global period. 15 minutes of intra time. 0.62 RVUs. In addition, a surgical code will be reported by the surgeon.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) CPT code 77431 in addition to varying other CPT codes (see rationale section)

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 Radiation Oncology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 6000

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 the Medicare population for IORT represents approximately 25% of the universe of these procedures.

Specialty Radiation Oncology Frequency 2000 Percentage 100.00 %

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? 1,500

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. We are estimating that approximately 1500 IORT treatments might be performed on Medicare patients in a one year period. Experts in IORT provided these estimates based on their familiarity the application of this procedure.

Specialty Radiation Oncology Frequency 1500 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?

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

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. 41019

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

CPT Long Descriptor: Intraoperative radiation treatment management

Global Period: XXX

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

CPT code 77469 *Intraoperative radiation treatment management* was approved at the October 2010 CPT Editorial Panel meeting. The code describes the physician work of intraoperative radiation treatment (IORT) management. It has been assigned an XXX global period and is typically performed in the facility setting.

ASTRO conducted a physician work survey for CPT code 77469. ASTRO convened a panel that included a number of experts familiar with this service to evaluate the RUC physician work survey data and prepare practice expense recommendations. The recommended direct practice expense inputs for CPT code 77469 are attached.

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 41019 *Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application* as the comparison code for our practice expense recommendations. IORT is similar to CPT code 41019, another open radiation oncology procedure. The resources used by the clinical staff are the same for IORT as CPT code 41019. CPT 41019 was recently approved by the RUC/PEAC (April 2007).

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Schedule procedure, confirm all applicable supplies and devices are available.

Retrieve and compile all relevant clinical information, including all preoperative imaging studies, and patient's medical record for review by the physician. Verify orders, and confirm procedure protocol with physician.

Contact patient on the day before the procedure to provide educational information regarding the procedure and provide them with any additional information they may request. Obtain informed consent and confirm adherence to pre procedure protocol.

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

Initiate phone calls for physician and call in prescriptions as applicable.

TAB 11 - REVSIED

AMA Specialty Society Recommendation

	A	B	C	D	E
1	AMA/Specialty Society RVS Update Committee Recommendation			77469	
2	Meeting Date: February 2011	CMS	Staff	Intraoperative radiation treatment management	
3	LOCATION	Code	Type	Non Facility	Facility
4	GLOBAL PERIOD				
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.0	28.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	25.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	3.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Complete pre-service diagnostic & referral forms	L037D	RN/LPN/MTA		5
12	Coordinate pre-surgery services	L037D	RN/LPN/MTA		10
13	Schedule space and equipment in facility	L037D	RN/LPN/MTA		5
14	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA		5
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	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	L037D	RN/LPN/MTA		3
43	Other Activity (please specify)				
44	End: with last office visit before end of global period				
45	MEDICAL SUPPLIES		Unit		
46					
47					
48					
49					
50	EQUIPMENT				
51					
52					

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Identified through the Harvard Valued – Utilization Over 100,000 Screen

February 2011

Hepatobiliary System Imaging

In October 2009, CPT code 78223 *Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function* was identified by the RUC's Relativity Assessment Workgroup through the Harvard Valued – Utilization over 100,000 screen. The specialty societies responded by reviewing the family of hepatobiliary codes and developing an action plan to reflect the current practice of reporting hepatobiliary system imaging and hepatobiliary system imaging with pharmacologic intervention, as well as in patients who have undergone cholecystectomy. CPT code 78220 *Liver function study with hepatobiliary agents, with serial image*, which had been previously performed with I-131Rose Bengal, a radiopharmaceutical no longer available, is an obsolete procedure and technique no longer performed. . In October 2010, the CPT Editorial Panel agreed that adding the language “gallbladder when present” would help to clarify the appropriate code to report for hepatobiliary imaging. The current CPT code family did not reflect the major difference in physician and technical work required to perform a study that includes pharmacological intervention. This includes both agents which stimulate gallbladder contraction and those used during assessment for acute cholecystitis (morphine sulfate), which may cause spasm at the Sphincter of Oddi, and can help differentiate between acute and chronic cholecystitis. Additionally, The CPT Editorial panel deleted codes 78223 and 78220 (an obsolete procedure), and created two new codes that better describe the services and differences in additional work when a pharmacological intervention is performed. The current CPT code 78223 will now be reported as either of the two new codes 78226 *Hepatobiliary system imaging, including gallbladder when present*; or 78227 *Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed*. It is expected that utilization will be reasonably split between 78226 (45%) and 78227 (55%). The RUC agreed that these utilization assumptions be reviewed for accuracy in three years.

78226 *Hepatobiliary system imaging, including gallbladder when present*

The RUC reviewed the survey results from 95 radiologists and nuclear medicine physicians who provide this service. The RUC agreed with the specialty society that the survey respondents overestimated the immediate post service time. The survey median immediate post-service time of 8.5 minutes was considered excessive for planar imaging and therefore the specialty recommended the immediate post-service time to be 5 minutes, which is consistent with other similar nuclear medicine procedure post-service time.

The RUC used magnitude estimation to develop a physician work RVU for 78226 by comparing the physician work of 78226 with the survey's key reference service 78707 *Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention* (work RVU = 0.96), and MPC code CPT 78306 *Bone and/or joint imaging; whole body* (work RVU=0.86) and agreed that these procedures are comparable in intensity and complexity to 78226. However, the RUC also agreed that 78226 should be valued lower than 78306 and higher than CPT code 76830 *Ultrasound, transvaginal* (work RVU = 0.69) considering the overall time, intensity, and complexity of the services. The RUC

assimilated the physician work effort of 78226 to CPT code 78580 *Pulmonary perfusion imaging, particulate* (work RVU = 0.74) and agreed that CPT code 78226 should have an identical work RVU. To maintain rank order within the Medicare physician fee schedule and remain budget neutral, the RUC agreed the appropriate work value for 78226 is 0.74 RVUs which is below the 25th percentile specialty survey results. **The RUC recommends a work RVU of 0.74 for CPT code 78226.**

78227 Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed

The RUC reviewed the survey results from 95 radiologists and nuclear radiologists who provide this service. The RUC agreed with the specialty societies that the survey respondents overestimated the immediate post service time. The survey median of 7 minutes was not typical for the service and therefore the specialty recommended the survey's 25th percentile post-service time of 5 minutes. The RUC agreed that this is consistent with similar nuclear medicine procedure post-service time.

The RUC used magnitude estimation to develop a physician work RVU for 78227 by comparing the reference service code chosen by the survey respondents, CPT 78707 *Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention* (RVW 0.96) and CPT 78306 *Bone and/or joint imaging; whole body* (Work RVU = 0.86) and recognized that 78227 has similar work intensity and complexity to 78707, but has higher intensity of medical decision making. Although 7828X2 requires similar intensity and complexity as CPT code 78306, it was agreed that 78227 should have a higher value because of the longer service time, total time of 26 minutes compared to 18 minutes for the reference code. The RUC also compared 78227 to CPT 78315 (*Bone and/or joint imaging; 3 phase study*) (work RVU = 1.02) and the agreed that 78227 should be valued lower because 78227 has much less intensity and complexity compared to the reference code. To maintain rank order across the Medicare physician fee schedule and remain budget neutral, the RUC agreed the appropriate work value for 78227 is 0.90 RVUs, which is below the 25th percentile specialty survey results. **The RUC recommends a work RVU of 0.90 for CPT code 78227.**

Work Neutrality

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

New Technology:

The RUC requested that CPT codes 78226 and 78227 be placed on the new technology list to review the volume of this service in three years to ensure that the utilization assumptions were accurate. Therefore, the RUC is adding these codes to the New Technology List solely to review claims data utilization between 78226 and 78227 to ensure the recommendation is work neutral.

Practice Expense:

The RUC discussed direct practice expense inputs at length for the hepatobiliary services under review. The RUC agreed with all of the recommended direct inputs for CPT codes 78226 and 78227.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 78220		Liver function study with hepatobiliary agents, with serial images	XXX	N/A
D 78223		Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function <u>(78220, 78223 have been deleted. To report, hepatobiliary system imaging, see 78226, 78227)</u>	XXX	N/A
●78226	K1	Hepatobiliary system imaging, including gallbladder when present	XXX	0.74
●78227	K2	with pharmacologic intervention, including quantitative measurement(s) when performed	XXX	0.90

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

CPT Code:78226 Tracking Number K1

Original Specialty Recommended RVU: **0.74**Presented Recommended RVU: **0.74**

Global Period: XXX

RUC Recommended RVU: **0.74**

CPT Descriptor: Hepatobiliary system imaging, including gallbladder when present

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 58-year-old woman presents with acute onset of right upper quadrant abdominal pain associated with nausea and vomiting. Ultrasonography of the gallbladder was unremarkable except for some right upper quadrant tenderness in the region of the gallbladder. A hepatobiliary study is ordered for suspected acute cholecystitis.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 2%

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? 1%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history, including the time since the previous meal, and available prior imaging studies, and determines the appropriateness of the requested study, prescribes, oversees and directs the administered radiopharmaceutical dose. The physician directs the technologist to adjust the acquisition protocol, as necessary, for the individual patient. This may include an injection of sincalide before the administration of the radiopharmaceutical, if the patient has fasted for a prolonged period. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.

Description of Intra-Service Work: Hepatobiliary scintigraphy is a diagnostic radionuclide imaging study that evaluates hepatocellular function and patency of the biliary system by tracing the production and flow of bile from the liver, and its passage through the biliary system into the gallbladder (when present) and into the small intestine. Sequential digital imaging data of the liver, biliary tree and gut are obtained.

Under the supervision of the physician, the technologist administers the radiopharmaceutical. The study consists of planar imaging typically for 60 minutes post-intravenous injection of the radiopharmaceutical, with additional views, e.g., right lateral, left or right anterior oblique(s), as needed to clarify anatomy. The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views or re-process data when necessary. The data are formatted for film and/or digital display. The physician reviews the study for artifacts and abnormal

distribution. The processed and raw images that are acquired are compared to relevant prior studies and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician provides regulatory review and oversight throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011				
Presenter(s):	Geraldine McGinty MD, Zeke Silva MD, Gary Dillehay MD				
Specialty(s):	The American College of Radiology, The Society of Nuclear Medicine				
CPT Code:	78226				
Sample Size:	1924	Resp N:	95	Response: 4.9 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		2.00	25.00	50.00	100.00
Survey RVW:		0.67	0.86	0.95	1.01
Pre-Service Evaluation Time:				5.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		3.00	10.00	10.00	15.00
Immediate Post Service-Time:		8.50			
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		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 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); 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:	78226	Recommended Physician Work RVU: 0.74		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	7.00	-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:		10.00		
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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
78707	XXX	0.96	RUC Time

CPT Descriptor Kidney imaging with vascular flow and function; single study without pharmacological intervention**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78306	XXX	0.86	RUC Time	521,587

CPT Descriptor 1 Bone and/or joint imaging; whole body

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
76700	XXX	0.81	RUC Time	1,020,282

CPT Descriptor 2 Ultrasound, abdominal, real time with image documentation; complete

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
76830	XXX	0.69	RUC Time

CPT Descriptor Ultrasound, transvaginal**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 33 % of respondents: 34.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 78226	<u>Key Reference CPT Code:</u> 78707	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	10.00	22.00	
Median Immediate Post-service Time	5.00	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	20.00	22.00	
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	2.54	2.86
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.07	3.07
--	------	------

Urgency of medical decision making	4.00	3.00
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	2.71	2.93
--------------------------	------	------

Physical effort required	2.04	2.07
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.68	2.32
---	------	------

Outcome depends on the skill and judgment of physician	3.37	3.54
--	------	------

Estimated risk of malpractice suit with poor outcome	3.00	2.54
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.53	2.52
----------------------------------	------	------

Intra-Service intensity/complexity	2.81	3.06
------------------------------------	------	------

Post-Service intensity/complexity	2.52	2.55
-----------------------------------	------	------

Additional Rationale and Comments

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

Tab 12 Hepatobiliary Family

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78223 (*Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic*

intervention, with or without quantitative measurement of gallbladder function) was identified as a potentially misvalued code through the over 100,000 utilization and it being a Harvard valued CPT code. The joint societies presented an action plan to include CPTs 78223 and CPT 78220 (*Liver function study with hepatobiliary agents, with serial images*) as part of a hepatobiliary family review with the plan to submit a CPT application in the 2012 CPT coding cycle. The joint societies believed that current practice with available radiopharmaceuticals would be better defined by two or more codes that describe the current procedures for hepatobiliary imaging, without separating hepatic from hepatic duct/gallbladder studies.

Additionally, our societies reviewed the coding questions received by our membership. We found the current hepatobiliary codes do not reflect current practice. Hepatobiliary imaging is now done with a single type of radiopharmaceutical (RP). CPT 78220, which was formerly performed with I-131Rose Bengal, an RP no longer available, is now done with the same RP used for gallbladder imaging and all other hepatobiliary imaging. Hepatobiliary imaging is occasionally requested to assess a bile leak in a post-operative patient who has had surgery involving the gallbladder and/or biliary tract. We believe that adding the language “gallbladder when present” will help to clarify the appropriate code to report. The current codes also do not reflect the major difference in physician and technical work required to perform a study that includes pharmacological intervention, whether or not there is quantification of gallbladder or hepatic function. This includes both agents which stimulate gallbladder contraction and those used during assessment for acute cholecystitis (morphine sulfate), which cause spasm at the Sphincter of Oddi, and can help differentiate between acute and chronic cholecystitis.

Survey Results & SNM/ACR Recommendations:

78226

A joint SNM and ACR RVS panel (SNM/ACR) reviewed and discussed the survey results. The SNM/ACR panel was pleased that there were 95 responses to the survey request. The survey performance rate median of 50 studies per year among the 95 respondents is a reasonable rate given this is a relatively low volume procedure, which adds support to the survey responses. The SNM/ACR panel agreed that the survey physician median times of 5 minutes pre-service, 10 minutes intra-service accurately reflect the time required to perform this service. Therefore we selected pre-service package 5 with 7 minutes of pre time and adjusted the time to our recommended value of 5 minutes. We believe the survey median 8 minutes immediate post-service time is excessive for planar imaging, therefore we recommend reducing the post time to 5 minutes which is consistent with other similar nuclear medicine procedure post-service times.

The current CPT code 78223 (RVU-0.84) will now be reported as either of the two new codes (78226 and 78227.). The SNM/ACR panel discussed at length compelling evidence arguments to support the survey median results. The SNM/ACR panel believed that the original Harvard value had likely undervalued this procedure. However, the reason for the current change in coding was to better describe the services and differences in additional work when a pharmacological intervention was performed, compared to a study done without intervention. These codes were surveyed in response to the RAW request, but we believe these procedures have not fundamentally changed over the years. Although the panel agreed there was increased work associated with 78227, the proposed values for the code pair results in budget neutrality, as there was insufficient compelling evidence for higher values for 78227. We continue to urge the RUC to accept “Harvard valued” as a criterion for compelling evidence, which we believe would apply to CPT 78223 and which we believe our survey data

We believe the reference service code chosen by the survey respondents, CPT 78707 *Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention*, (RVW 0.96) has higher work intensity and complexity than 78226, and as the survey correctly reflects, similar or lower intensity of medical decision making.

The SNM/ACR panel reviewed the split of the two procedures in order to ensure our values would remain within budget neutrality and maintain rank order. Our expert panel believes that the higher volume service will be 78227. The ACR/SNM panel agreed there was variation in the mix of how providers performed these two procedures, with industry reporting the 78226 /78227 ratio as 50/50. We looked to the 95 respondents’ of our survey, with median response rate 41/59, blended and the expert panel agreed that a reasonable split would be 45 percent 78226 to 55 percent for 78227.

We compared 78226 to a MPC code CPT 78306 (*Bone and/or joint imaging; whole body*), (RVW 0.86). While we believe these procedures are comparable in intensity and complexity the SNM/ACR panel would agree that 78226 should be valued lower (RVW 0.74) than 78306 and higher than CPT 76830 (*Ultrasound, transvaginal*), (RVW 0.69). We also

Specialty Independent Diagnostic Testing Frequency 7715 Percentage 9.15 %

Specialty Nuclear Medicine Frequency 6031 Percentage 7.15 %

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

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. 78223

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

CPT Code: 78227 Tracking Number K2 Original Specialty Recommended RVU: **0.90**
Presented Recommended RVU: **0.90**
Global Period: XXX RUC Recommended RVU: **0.90**

CPT Descriptor: Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 47-year-old woman presents with a history of intermittent right upper quadrant abdominal pain often associated with ingestion of a fatty meal. Work up, including gallbladder ultrasonography and upper endoscopy, is unremarkable. A hepatobiliary study is ordered for evaluation including gallbladder function.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 1%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history including the time since the previous meal, and available prior imaging studies, and determines the appropriateness of the requested study; prescribes, oversees and directs the administered drug(s) and radiopharmaceutical dose(s). The physician directs the technologist to adjust the acquisition protocol, as necessary, for the individual patient. This may include an injection of sincalide before the administration of the radiopharmaceutical, if the patient has fasted for a prolonged period. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.

Description of Intra-Service Work: Hepatobiliary scintigraphy with pharmacological intervention is a diagnostic radionuclide imaging study that evaluates hepatocellular function and patency of the biliary system by tracing the production and flow of bile from the liver, and its passage through the biliary system into the gallbladder (when present) and into the small intestine. Pharmacological interventions during imaging are employed according to varying indications and individual patient needs.

Under the supervision of the physician, the technologist administers the radiopharmaceutical(s) and drug(s).

The study consists of sequential digital imaging of the liver, biliary tree and gut for up to 60 minutes post intravenous injection of the radiopharmaceutical, with additional views, e.g., right lateral, left or right anterior oblique as needed to clarify anatomy. To measure gallbladder function (ejection fraction), sequential imaging data of the visualized gallbladder

is acquired during a prolonged (45 - 60 minutes) intravenous infusion of sincalide. The physician determines the timing and quantity of an intravenous administration of sincalide and the time of the administration is noted for calculations of gallbladder ejection fraction (GBEF).

The physician verifies the completeness and adequacy of the images before completion of the study and directs the technologist to obtain additional views or re-process data when necessary. The digital data are formatted for film and/or digital display and analysis. Cinematic display of images may be done to assist the physician, review measurements of gallbladder or hepatic function, if performed. The physician reviews the study for artifacts, correct regions-of-interest placement and abnormal distribution. The processed and raw images are compared to relevant prior studies and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician provides regulatory review and oversight throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011				
Presenter(s):	Geraldine McGinty MD, Zeke Silva MD, Gary Dillehay MD				
Specialty(s):	The American College of Radiology and The Society of Nuclear Medicine				
CPT Code:	78227				
Sample Size:	1924	Resp N:	95	Response: 4.9 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	35.00	60.00	130.00
Survey RVW:		0.70	0.95	1.02	2.20
Pre-Service Evaluation Time:				7.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		3.00	10.00	15.00	20.00
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:	0.00	99238x 0.00	99239x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 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); 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:	78227	Recommended Physician Work RVU: 0.90		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		6.00	7.00	-1.00
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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
78707	XXX	0.96	RUC Time

CPT Descriptor Kidney imaging with vascular flow and function; single study without pharmacological intervention**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78306	XXX	0.86	RUC Time	521,587

CPT Descriptor 1 Bone and/or joint imaging; whole body

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78315	XXX	1.02	RUC Time	112,370

CPT Descriptor 2 Bone and/or joint imaging; 3 phase study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 28 % of respondents: 29.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 78227	<u>Key Reference CPT Code:</u> 78707	<u>Source of Time</u> RUC Time
Median Pre-Service Time	6.00	0.00	
Median Intra-Service Time	15.00	22.00	
Median Immediate Post-service Time	5.00	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	26.00	22.00	
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	2.61	2.86
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.89	3.00
--	------	------

Urgency of medical decision making	3.07	2.75
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	2.79	2.82
--------------------------	------	------

Physical effort required	1.93	1.93
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.43	2.25
---	------	------

Outcome depends on the skill and judgment of physician	3.32	3.39
--	------	------

Estimated risk of malpractice suit with poor outcome	2.93	2.82
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.36	2.36
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Intra-Service intensity/complexity	3.07	3.21
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Post-Service intensity/complexity	2.57	2.68
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Additional Rationale and Comments

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

Tab 12 Hepatobiliary Family

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78223 (*Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic*

intervention, with or without quantitative measurement of gallbladder function) was identified as a potentially misvalued code through the over 100,000 utilization and it being a Harvard valued CPT code. The joint societies presented an action plan to include CPTs 78223 and CPT 78220 (*Liver function study with hepatobiliary agents, with serial images*) as part of a hepatobiliary family review with the plan to submit a CPT application in the 2012 CPT coding cycle. The joint societies believed that current practice with available radiopharmaceuticals would be better defined by two or more codes that describe the current procedures for hepatobiliary imaging, without separating hepatic from hepatic duct/gallbladder studies.

Additionally, our societies reviewed the coding questions received by our membership. We found the current hepatobiliary codes do not reflect current practice. Hepatobiliary imaging is now done with a single type of radiopharmaceutical (RP). CPT 78220, which was formerly performed with I-131Rose Bengal, an RP no longer available, is now done with the same RP used for gallbladder imaging and all other hepatobiliary imaging. Hepatobiliary imaging is occasionally requested to assess a bile leak in a post-operative patient who has had surgery involving the gallbladder and/or biliary tract. We believe that adding the language “gallbladder when present” will help to clarify the appropriate code to report. The current codes also do not reflect the major difference in physician and technical work required to perform a study that includes pharmacological intervention, whether or not there is quantification of gallbladder or hepatic function. This includes both agents which stimulate gallbladder contraction and those used during assessment for acute cholecystitis (morphine sulfate), which cause spasm at the Sphincter of Oddi, and can help differentiate between acute and chronic cholecystitis.

Survey Results & SNM/ACR Recommendations:

78227

A joint SNM and ACR RVS panel (SNM/ACR) reviewed and discussed the survey results. The SNM/ACR panel was pleased that there were 95 responses to the survey request. The survey performance rate median of 60 studies per year among the 95 respondents is a reasonable rate given this is a relatively low volume procedure, which adds support to the survey responses. The SNM/ACR panel agreed that the survey physician 25th percentile times of 6 minutes pre-service, 15 minutes intra-service and 5 minutes post time accurately reflect the time required for this service. Therefore we selected pre-service package 5 with 7 minutes of pre time and adjusted the time to our recommended value of 6 minutes. We believe the survey median were excessive for this service, our recommendation reflect the expert panels review of other similar nuclear medicine procedure times.

The current CPT code 78223 (RVU-0.84) will now be reported as either of the two new codes (78226 and 78227.). The SNM/ACR panel discussed at length compelling evidence arguments to support the survey median results. The SNM/ACR panel believed that the original Harvard value had likely undervalued this procedure. However, the reason for the current change in coding was to accurately reflect the services and differences in additional work when a pharmacological intervention was performed, compared to a study done without intervention. These codes were surveyed in response to the RAW request, but we believe these procedures have not fundamentally changed over the years. Although the panel agreed there was increased work associated with 78227, the proposed values for the code pair results in budget neutrality, as there was insufficient compelling evidence for higher values for 78227.

The SNM/ACR panel reviewed the split of the two procedures in order to ensure our values would remain within budget neutrality and maintain rank order. Our expert panel believes that the higher volume service will be 78227. The ACR/SNM panel agreed there was variation in the mix of how providers performed these two procedures, with industry reporting the 78226/78227 ratio as 50/50. We looked to the 95 respondents' of our survey, with median response rate 41/59, blended and the expert panel agreed that a reasonable split would be 45 percent 78226 to 55 percent for 78227.

We believe the reference service code chosen by the survey respondents, CPT 78707 *Kidney imaging morphology; with vascular flow and function, single study without pharmacological intervention* (RVW 0.96) has similar work intensity and complexity than 78227, but higher intensity of medical decision making, all of which is reflected in our survey data.

We compared 78227 to CPT 78306 (*Bone and/or joint imaging; whole body*), RVW 0.86. While we believe these procedures are comparable in intensity and complexity, the SNM/ACR panel would agree that 78227 should have a higher value than 78306. We also compared 78227 to CPT 78315 (*Bone and/or joint imaging; 3 phase study*), RVW 1.02, and the panel agrees that 78227 should be ranked lower.

Specialty Nuclear Medicine

Frequency 7371

Percentage 7.15 %

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

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. 78223

Hepatobiliary Family

Medicare Volume	X-walk(s)	Description	Code	SVY 50% Median	SVY 25%	Current RVW	RVW REC	Total Time	Pre	Intra	Post
Hepatobiliary Imaging Family											
184,489	78223	Hepatobiliary w/out pharm	78226	0.95	0.86	0.84	0.74	20	5	10	5
184,489	78223	Hepatobiliary with pharm	78227	1.02	0.95	0.84	0.90	26	6	15	5
Mag Est Comparision Codes							RVW	Total Time	Pre	Intra	Post
38,946	Mag Est 26	Ultrasound, transplanted kidney	76776	N/A	N/A	N/A	0.76	20	5	10	5
9	Mag Est 26	Ultrasound, infant hips, real time	76885	N/A	N/A	N/A	0.74	20		20	
316,798	Mag Est 27	Echo, transthoracic, (2D), comp	93307	N/A	N/A	N/A	0.92	28	5	18	5

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

CPT Long Descriptor:

Hepatobiliary system imaging, including gallbladder when present

Global Period: XXX

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

We convened a joint SNM and ACR expert panel with varying geographic regions and varying experiences.

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

We have included the current CMS inputs for CPT 78223 *Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function* for comparison.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review x-ray, lab and past test to confirm appropriates with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy
- QC Planar Equipment
- Prepare radiopharmaceutical (RP) (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.

Intra-Service Clinical Labor Activities:

- Greet patient and provide gowning
- Review mandatory radiation education; verbal consent
- Prepare room, equipment, supplies, change collimator and set up protocol
- Position patient/ monitor patient/ set up any flow imaging
- Obtain RP & or Pharm Intervention from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)
- Placement of IV; administration of RP
- Acquire images and review for completeness, quality, and time
- Instruction/Counseling as patient is taken back to waiting area after each scanning session with an emphasis on radiation risk to those at home.

- Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient

Post-Service Clinical Labor Activities:

- Clean room/equipment by physician staff
- Specific room clean up of RP injection areas with defacement of labels
- Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.

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

CPT Long Descriptor:

Hepatobiliary system imaging, including gallbladder when present: with pharmacologic intervention, including quantitative measurement(s) when performed

Global Period: XXX

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

We convened a joint SNM and ACR expert panel with varying geographic regions and varying experiences.

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

We have included the current CMS inputs for CPT 78223 *Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function,* for comparison.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review x-ray, lab and past test to confirm appropriates with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy
- QC Planar Equipment
- Prepare radiopharmaceutical (RP) (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.

Intra-Service Clinical Labor Activities:

- Greet patient and provide gowning
- Review mandatory radiation education; verbal consent
- Prepare room, equipment, supplies, change collimator and set up protocol
- Position patient/ monitor patient/ set up any flow imaging
- Obtain RP & or Pharm Intervention from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)
- Placement of IV; administration of RP
- Acquire images and review for completeness, quality, and time, review interim images with physician to obtain continued imaging instruction(s)

- Instruction/Counseling as patient is taken back to waiting area after each scanning session(s) (with pharmacological intervention procedures involves multiple scanning sessions) with an emphasis on radiation risk to those at home.
- Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient

Post-Service Clinical Labor Activities:

- Clean room/equipment by physician staff
- Specific room clean up of RP injection areas with defacement of labels
- Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.

	A	B	C	E	F
1	AMA/Specialty Society RVS Update Committee Recommendation			78226	78227
2	Meeting Date: January - February 2011 Hepatobiliary Family			Hepatobiliary system imaging, including gallbladder when present;	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed
3		CMS	Staff		
4		Code	Type	Non Facility	Non Facility
5	TOTAL CLINICAL LABOR TIME			XXX	XXX
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L049A	NMT	139.0	178.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L049A	NMT	20.0	20.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L049A	NMT	109.0	148.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Review x-ray, lab and past test to confirm appropriateness with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy	L049A	NMT	3	3
12	QC Planar Equipment	L049A	NMT	4	4
13	Prepare radiopharmaceutical (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.	L049A	NMT	13	13
14	End: When patient enters office/facility for surgery/procedure	L049A			
15	SERVICE PERIOD				
16	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
17	Greet patient and provide gowning	L049A	NMT	3	3
18	Review mandatory radiation education; verbal consent	L049A	NMT	4	4
19	Prepare room, equipment, supplies, change collimator and set up protocol	L049A	NMT	4	4
20	Intra-service	L049A			
21	Position patient/ monitor patient/ set up any flow imaging / prepare during stress procedure if performed / set up ECG if gating	L049A	NMT	2	2
22	Instruction/Counseling as patient is taken back to waiting area after each scanning session	L049A	NMT	0	0
23	Obtain RP & or Pharm Intervention from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)	L049A	NMT	5	10
24	Placement of IV; tech present during injection of RP and if appropriate Pharm intervention	L049A	NMT	7	12
25	Acquire images and review for completeness and quality, and time	L049A	NMT	60	90
26	Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient	L049A	NMT	10	10
27	Post-Service	L049A			
28	Clean room/equipment by physician staff	L049A	NMT	3	3
29	Specific room clean up of RP injection areas with defacement of labels	L049A	NMT	4	4
30	Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.	L049A	NMT	3	3
31	End: Patient leaves office	L049A			
32	POST-SERVICE Period				
33	None				

	A	B	C	E	F
1	AMA/Specialty Society RVS Update Committee Recommendation			78226	78227
2	Meeting Date: January - February 2011 Hepatobiliary Family	CMS	Staff	Hepatobiliary system imaging, including gallbladder when present;	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed
3		Code	Type	Non Facility	Non Facility
34	MEDICAL SUPPLIES		Unit		
35	pack, minimum multi-specialty visit	SA048		1	1
36	drape, non-sterile, sheet 40in x 60in	SB006		2	2
37	Non-sterile gloves	SB022		1	2
38	underpad 2ft x 3ft (Chux)	SB044		2	2
39	angiocatheter 14g-24g	SC001		1	1
40	heparin lock	SC012			1
41	needle, 18-27g	SC029		1	2
42	stop cock, 3-way	SC049		1	1
43	syringe 10-12ml	SC051		1	2
44	bandage, strip 0.75in x 3in (Bandaid)	SG021		1	1
45	gauze, non-sterile 2in x 2in	SG050		2	2
46	heparin lock flush soln	SH040			1
47	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068		1	2
48	swab-pad, alcohol	SJ053		4	4
49	film, x-ray 8in x 10in	SK037		4	4
50	x-ray developer solution	SK089		1	1
51	x-ray envelope	SK091		1	1
52	x-ray fixer solution	SK092		2	2
53	sanitizing cloth-wipe (surface, instruments, equipment)	SM022		10	10
54	Equipment			Time in minutes	Time in minutes
55	Cobalt-57 Flood Source (47cm dia) (10 mCi)	ER001		4	4
56	computer workstation, nuclear medicine analysis	ED019		10	15
57	computer workstation, nuclear pharmacy management (hardware and software)	ED020		24	29
58	Film processor, wet	ED025		5	5
59	dose calibration source vial set (Cs137, Co57, and Ba137)	ER026		16	16
60	dose calibrator (Atomlab)	ER027		28	33
61	gamma camera system, single-dual head	ER032		83	113
62	radiation L-block tabletop shield	ER053		28	33
63	radiation survey meter	ER054		20	20
64	safe, storage, lead-lined	ER058		28	33
65	x-ray view box, 4 panel	ER067		10	10

	A	B	C	E	F
1	AMA/Specialty Society RVS Update Committee Recommendation			78226	78227
2	Meeting Date: January - February 2011 Hepatobiliary Family			Hepatobiliary system imaging, including gallbladder when present;	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed
3		CMS	Staff		
4		Code	Type	Non Facility	Non Facility
5	TOTAL CLINICAL LABOR TIME			XXX	XXX
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L049A	NMT	132.0	174.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L049A	NMT	20.0	20.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L049A	NMT	99.0	141.0
9	PRE-SERVICE				
10	Start: Following visit when decision for surgery or procedure made				
11	Review x-ray, lab and past test to confirm appropriateness with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy	L049A	NMT	3	3
12	QC Planar Equipment	L049A	NMT	4	4
13	Prepare radiopharmaceutical (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.	L049A	NMT	13	13
14	End: When patient enters office/facility for surgery/procedure	L049A			
15	SERVICE PERIOD				
16	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure				
17	Greet patient and provide gowning	L049A	NMT	3	3
18	Review mandatory radiation education; verbal consent	L049A	NMT	3	3
19	Prepare room, equipment, supplies, change collimator and set up protocol	L049A	NMT	3	3
20	Intra-service	L049A			
21	Position patient/ monitor patient/ set up any flow imaging / prepare during stress procedure if performed / set up ECG if gating	L049A	NMT	5	7
22	Instruction/Counseling as patient is taken back to waiting area after each scanning session	L049A	NMT	3	3
23	Obtain RP & or Pharm Intervention from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)	L049A	NMT	5	10
24	Placement of IV; tech present during injection of RP and if appropriate Pharm intervention	L049A	NMT	7	12
25	Acquire images and review for completeness and quality, and time	L049A	NMT	60	90
26	Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient	L049A	NMT	10	10
27	Post-Service	L049A			
28	Clean room/equipment by physician staff	L049A	NMT	3	3
29	Specific room clean up of RP injection areas with defacement of labels	L049A	NMT	5	5
30	Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.	L049A	NMT	5	5
31	End: Patient leaves office	L049A			
32	POST-SERVICE Period				
33	None				

	A	B	C	E	F
1	AMA/Specialty Society RVS Update Committee Recommendation			78226	78227
2	Meeting Date: January - February 2011 Hepatobiliary Family	CMS	Staff	Hepatobiliary system imaging, including gallbladder when present;	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed
3		Code	Type	Non Facility	Non Facility
34	MEDICAL SUPPLIES		Unit		
35	pack, minimum multi-specialty visit	SA048		1	1
36	drape, non-sterile, sheet 40in x 60in	SB006		2	2
37	Non-sterile gloves	SB022		1	2
38	underpad 2ft x 3ft (Chux)	SB044		2	2
39	angiocatheter 14g-24g	SC001		1	1
40	heparin lock	SC012			1
41	needle, 18-27g	SC029		1	2
42	stop cock, 3-way	SC049		1	1
43	syringe 10-12ml	SC051		1	2
44	bandage, strip 0.75in x 3in (Bandaid)	SG021		1	1
45	gauze, non-sterile 2in x 2in	SG050		2	2
46	heparin lock flush soln	SH040			1
47	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068		1	2
48	swab-pad, alcohol	SJ053		4	4
49	film, x-ray 8in x 10in	SK037		4	4
50	x-ray developer solution	SK089		1	1
51	x-ray envelope	SK091		1	1
52	x-ray fixer solution	SK092		2	2
53	sanitizing cloth-wipe (surface, instruments, equipment)	SM022		10	10
54	Equipment			Time in minutes	Time in minutes
55	Cobalt-57 Flood Source (47cm dia) (10 mCi)	ER001		4	4
56	computer workstation, nuclear medicine analysis	ED019		10	15
57	computer workstation, nuclear pharmacy management (hardware and software)	ED020		26	31
58	Film processor, wet	ED025		5	5
59	dose calibration source vial set (Cs137, Co57, and Ba137)	ER026		16	16
60	dose calibrator (Atomlab)	ER027		31	36
61	gamma camera system, single-dual head	ER032		85	117
62	radiation L-block tabletop shield	ER053		31	36
63	radiation survey meter	ER054		23	23
64	safe, storage, lead-lined	ER058		31	36
65	x-ray view box, 4 panel	ER067		10	10

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Identified through the Harvard Valued – Utilization Over 100,000 Screen

February 2011

Pulmonary Imaging

As a result of the RUC's Relativity Assessment Workgroup (RAW), CPT 78585 (*Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath*) was identified as a potentially misvalued code through the Harvard Valued – Utilization Over 100,000 screen. Specialty societies presented an action plan to the RAW to include CPT codes 78580-78596 as part of the Pulmonary (Lung) family review, to consolidate 9 codes into 5 at the October 2010 CPT Editorial Panel meeting for CPT 2012.

The CPT Editorial Panel consolidated all codes describing the ventilation part of the studies, as the pulmonary code family was previously comprised of several ventilation codes that were based on a gas versus aerosol method, and also included single view and multiple view ventilation studies, which made choosing the appropriate code difficult. The specialty societies agreed that there is little work or cost difference between a gas and aerosol technique and recommended using the same codes, whether the ventilation portion of the study is done with a gas or with aerosolized particles. There was also some ambiguity about the appropriate code for pulmonary function quantification, since there was currently only one pulmonary quantification code, which is used for measurement of both ventilation and perfusion. The typical patient service usually involved measurement of just perfusion, either regional or global and not both ventilation and perfusion. The specialty societies and the CPT Editorial Panel agreed that this new structure of the pulmonary section simplified the coding of these studies and clearly addresses all the possible nuclear medicine lung studies currently performed. In addition, the new coding structure should result in savings to the Medicare program, while also maintaining relativity within the pulmonary family of codes, relativity with other radiology codes, and maintaining budget neutrality.

78579 Pulmonary ventilation imaging (eg, aerosol or gas)

The RUC reviewed the joint specialty society survey results from 85 physicians who perform this service. The RUC agreed with the surveyed physician median time of 5 minutes pre-service and 5 minutes of post service. The RUC agreed with the specialty that the survey median 10 minutes intra-service time is not appropriate for ventilation only imaging, therefore recommend the 25th percentile at 5 minutes for intra-service time, which is more typical.

The RUC compared 78579 to the survey respondents key reference code CPT 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 5 minutes pre-service, 8 minutes intra-service, 5 minutes post service), and agreed that although they are comparable services, the work of 78579 involves fewer images and less time and work than 78306. The RUC also compared 78579 to CPT 75571 *Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium* (work RVU = 0.58, 5 minutes pre-service, 10 minutes intra-service, 5 minutes post service) and concurred that procedure's work and physician time are even more alike.

Although below the specialty society's 25th percentile survey results, the specialty indicated and the RUC agreed, that the physician work value of 78579 should be cross-walked to the existing service of 78593 *Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection* (work RVU = 0.49), to maintain rank order and remain budget neutral. **The RUC recommends a work RVU of 0.49 for CPT Code 78579.**

78580 *Pulmonary perfusion imaging (eg, particulate)*

The RUC reviewed the joint specialty society survey results from 85 physicians who perform this service. The survey respondents indicated 7 minutes was necessary for providing the pre-service evaluation, however the specialty recommended 5 minutes of pre-service time to be consistent with other nuclear medicine services and reflects the typical patient scenario. The RUC agreed with the specialty recommended physician time of 5 minutes pre-service, 10 minutes intra-service, and 5 minutes of post service.

The RUC reviewed the median and 25th percentile survey results in comparison to the survey respondents key reference code CPT 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86, 5 minutes pre-service, 8 minutes intra-service, 5 minutes post service), and agreed that although they are comparable services, the work of 78580 involves fewer images and less work intensity and complexity than that of 78306. The specialty and the RUC agreed that the work of 78580 had not fundamentally changed over the years and that maintaining the current work value of 0.74, which is below the survey's 25th percentile survey results, would be appropriate to maintain rank order for this family of services. **The RUC recommends a work RVU of 0.74 for CPT Code 78580.**

78582 *Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging*

The RUC reviewed the joint specialty society survey results from 85 physicians who perform this service. The survey respondents indicated 7 minutes was necessary for providing the pre-service evaluation, however the specialty recommended 5 minutes to be consistent with other nuclear medicine services and reflects the typical patient scenario. The RUC agreed with the specialty recommended physician time of 5 minutes pre-service, 12 minutes intra-service, and 10 minutes of post service, as typical for the two studies and multiple sets of images being acquired.

The RUC agreed that two distinct and separate procedures, a pulmonary ventilation and a pulmonary perfusion study, are both performed sequentially at the same session. This multiple study procedure is similar to other nuclear medicine procedures involving multiple studies such as planar myocardial perfusion imaging CPT code 78454 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.34). CPT code 78454 was chosen as the key reference service by the survey respondents and although they indicated CPT code 78582 was more intense and complex, the survey median work RVU of 1.07, indicated slightly less overall physician work. The RUC agreed that CPT code 78454 is a good comparison to CPT code 78582, and the RUC agreed that the complexity of reviewing multiple studies, along with reviewing medications and the stress test, supports the higher value RVW of 1.34 for 78454, compared to surveyed code 78582.

The RUC also compared 78582 to the current value of the two highest volume CPT crosswalk codes CPT 78585 *Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath* (work RVU = 1.09) and CPT 78588 *Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, 1 or multiple projections* (work RVU = 1.09), both of which have an RVW of 1.09, which supports the median survey result. The overall physician work was also assimilated and compared to another multiple procedure nuclear medicine study CPT 78804 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging* (work RVU = 1.07). Considering the work values of these crosswalk and comparison codes, the RUC agreed that the specialty's survey median work RVU of 1.07 appropriately accounts for the physician work required to perform CPT code 78582. **The RUC recommends a work RVU of 1.07 for CPT Code 78582.**

78597 Quantitative differential pulmonary perfusion, including imaging when performed

The RUC reviewed the joint specialty society survey results from 58 physicians who frequently perform this service. The RUC agreed with the specialty recommended physician time of 5 minutes pre-service, 10 minutes intra-service, and 5 minutes of post service, as typical for this service.

The RUC and the specialty agreed that the typical study is not of greater work than the non-quantitative, diagnostic pulmonary imaging studies. In addition, deleted code CPT 78596 *Pulmonary quantitative differential function (ventilation/perfusion) study* (work RVU = 1.27) may not have been appropriately ranked relative to other nuclear medicine procedures. This is higher than any of the single or multiple pulmonary ventilation or perfusion study codes. The RUC agreed that the reference service chosen by the survey respondents, CPT 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86) has more work intensity and complexity than the new pulmonary perfusion quantitative CPT code 78597. The RUC also compared CPT 78597 to 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* (work RVU = 0.75) and found them analogous in work and total time 23 minutes and 20 minutes, respectively.

The RUC recommends a work RVU of 0.75, which is below the specialty's 25th percentile survey results, to maintain rank order and budget neutrality for this family of services. **The RUC recommends a work RVU of 0.75 for CPT Code 78597.**

78598 Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed

The RUC reviewed the joint specialty society survey results from 58 physicians who frequently perform this service. The RUC agreed with the specialty recommended physician time of 5 minutes pre-service, 10 minutes intra-service, and 9 minutes of post service, as typical for this service.

The RUC reviewed the survey median and 25th percentile work relative values of 1.04 and 0.84 respectively, and agreed that the typical quantitative studies are not of greater work than the non-quantitative, diagnostic pulmonary imaging studies. In addition, deleted code CPT 78596 *Pulmonary quantitative differential function (ventilation/perfusion) study* (work RVU = 1.27) may not have been appropriately ranked relative to other nuclear medicine procedures. This is higher than any of the single or multiple pulmonary ventilation or perfusion study codes.

The RUC agreed that the reference service code chosen by the survey respondents CPT 78454 *Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection* (work RVU = 1.34) has more work intensity

and complexity than the new multiple quantitative pulmonary perfusion CPT 78598. The RUC also compared CPT 78598 to MPC code CPT 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86 and total time= 18 minutes) and CPT 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81 and total time= 17 minutes) and found them comparable in physician work and time.

The RUC recommends a work RVU of 0.85, which is the specialty’s 25th percentile survey results, to maintain rank order and budget neutrality for this family of services. **The RUC recommends a work RVU of 0.85 for CPT Code 78597.**

Work Neutrality

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

Practice Expense: RUC carefully reviewed the direct practice expense inputs recommended by the specialty societies and approved the clinical labor, supplies and equipment associated with these services.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●78579	L1	Pulmonary ventilation imaging (eg, aerosol or gas)	XXX	0.49
▲78580	L2	Pulmonary perfusion imaging (eg, particulate)	XXX	0.74 (No Change)
●78582	L3	Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging	XXX	1.07
D 78584		Pulmonary perfusion imaging, particulate, with ventilation; single breath	XXX	N/A
D 78585		Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath	XXX	N/A
D 78586		Pulmonary ventilation imaging, aerosol; single projection	XXX	N/A
D 78587		Pulmonary ventilation imaging, aerosol; multiple projections (eg, anterior, posterior, lateral views)	XXX	N/A

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 78588		Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, 1 or multiple projections	XXX	N/A
D 78591		Pulmonary ventilation imaging, gaseous, single breath, single projection	XXX	N/A
D 78593		Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection	XXX	N/A
D 78594		Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; multiple projections (eg, anterior, posterior, lateral views)	XXX	N/A
D 78596		Pulmonary quantitative differential function (ventilation/perfusion) study	XXX	N/A
●78597	L4	Quantitative differential pulmonary perfusion, including imaging when performed	XXX	0.75
●78598	L5	Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed (Report 78579, 78580, 78582-78598 only once per imaging session) (Do not report 78580, 78582-78598 in conjunction with 78451-78454) (78584-78596 have been deleted. To report, see 78579, 78582-78598)	XXX	0.85

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

CPT Code: 78579 Tracking Number L1 Original Specialty Recommended RVU: **0.60**
 Presented Recommended RVU: **0.49**
 Global Period: XXX RUC Recommended RVU: **0.49**

CPT Descriptor: Pulmonary ventilation imaging (eg, aerosol or gas)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old man has recent onset of obstructive pulmonary disease. A pulmonary ventilation study is ordered to determine the extent of disease.

Percentage of Survey Respondents who found Vignette to be Typical: 58%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 2%

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? 1%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history, available prior imaging studies, and determines the appropriateness of the requested study, prescribes, oversees and directs the administered radiopharmaceutical dose. The physician directs the technologist to adjust the acquisition protocol, as necessary, for the individual patient. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.

Description of Intra-Service Work: Lung ventilation scintigraphy is a radionuclide diagnostic imaging study that records the bronchopulmonary distribution of an inhaled radioactive aerosol or gas within the lungs. Multiple images of the lungs are acquired. Under the supervision of the physician, the technologist gives specific breathing instructions to the patient while administering the radiopharmaceutical. The study consists of multiple images (e.g. anterior, posterior, right and left anterior & posterior obliques, right and left laterals) and documentation of patient position. The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views, when necessary.

The data are formatted for film and/or digital display and analysis. The physician reviews the study for artifacts and abnormal distribution. The processed and raw images (eg, upright or supine, posterior, left anterior oblique, etc.) are compared to a current chest x-ray and relevant prior studies, and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician provides regulatory review and oversight throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011					
Presenter(s):	Geraldine McGinty MD, Zeke Silva MD, Gary Dillehay MD					
Specialty(s):	The American College of Radiology, The Society of Nuclear Medicine					
CPT Code:	78579					
Sample Size:	1924	Resp N:	85	Response:	4.4 %	
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		1.00	2.00	5.00	10.00	100.00
Survey RVW:		0.15	0.60	0.80	1.00	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:		1.00	5.00	10.00	13.50	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 0.00	99239x 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); 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:	78579	Recommended Physician Work RVU: 0.49		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	7.00	-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:	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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
78306	XXX	0.86	RUC Time

CPT Descriptor Bone and/or joint imaging; whole body**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78306	XXX	0.86	RUC Time	521587

CPT Descriptor 1 Bone and/or joint imaging; whole body

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11721	000	0.54	RUC Time	7,382,193

CPT Descriptor 2 Debridement of nail(s) by any method(s); 6 or more

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
75571	XXX	0.58	RUC Time

CPT Descriptor Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 27.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 78579	<u>Key Reference CPT Code:</u> 78306	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	5.00	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	15.00	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	2.81	3.05
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.71	2.81
Urgency of medical decision making	2.71	2.95

Technical Skill/Physical Effort (Mean)

Technical skill required	2.81	2.76
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Physical effort required	2.14	2.24
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.38	2.38
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Outcome depends on the skill and judgment of physician	2.90	2.81
--	------	------

Estimated risk of malpractice suit with poor outcome	2.43	2.67
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.14	2.19
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Intra-Service intensity/complexity	2.62	2.57
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Post-Service intensity/complexity	2.24	2.29
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Additional Rationale and Comments

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

Tab 13 Pulmonary Family

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78585 (*Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or*

without single breath) was identified as a potentially misvalued code through the Harvard Valued, over 100,000 utilization screen. The joint societies presented an action plan to the RAW to include CPTs 78580 through CPT 78596 as part of a Pulmonary (Lung) family review, with a plan to submit a CPT application in the 2012 CPT coding cycle.

The current pulmonary code family has several ventilation codes that are based on a gas versus aerosol method, and including single view and multiple view ventilation studies, which can make choosing the appropriate code difficult. Our societies believe that there is little work or cost difference between a gas and aerosol technique and recommend using the same codes, whether the ventilation portion of the study is done with a gas or with aerosolized particles. We are recommending consolidation of the codes describing the ventilation part of the study. There is also some ambiguity about the appropriate code for pulmonary function quantification, since there is currently only one pulmonary quantification code, which is used for measurement of both ventilation and perfusion. The current practice usually involves measurement of just perfusion, either regional or global and not both ventilation and perfusion. We believe this new structure of the pulmonary section simplifies the coding of these studies and will clearly address all the possible nuclear medicine lung studies currently performed.

The specialty chose to survey the entire family of pulmonary codes. We believe these procedures have not fundamentally changed over the years and condensing the current pulmonary family of 10 CPT codes into 5 new or revised pulmonary CPT codes will result in some savings to the system, while also maintaining relativity within the pulmonary family of codes, maintain relativity with other radiology codes and maintain budget neutrality.

Survey Results & SNM/ACR Recommendations:

78579

A joint SNM and ACR RVS panel (SNM/ACR) reviewed and discussed the survey results. The SNM/ACR panel was pleased that there were 85 responses to the survey request. The survey performance rate median of 5 studies per year among the 85 respondents is an understandable rate given this is a very low volume procedure. The SNM/ACR panel agreed that the survey physician median time of 5 minutes pre-service and 5 minutes of post service accurately reflect the time required to perform this service. Therefore we selected pre-service package 5 with 7 minutes of pre time and adjusted the time to our recommended value of 5 minutes consistent with other nuclear medicine procedures. We believe the survey median 10 minutes intra-service time is not appropriate for ventilation only imaging, therefore we recommend accepting the 25th percentile at 5 minutes for intra-service time.

There are five current codes which describe ventilation only imaging, CPT's 78586, 78587, 78591, 78593, 78594, with the two highest volume codes having RVW values of 0.49 and 0.53, respectively. The expert panel agreed that it is rare to perform a ventilation only study. The panel believes that some of the volume may have been attributed to providers unintentionally unbundling and billing the perfusion separate from the ventilation study. The societies have increased education efforts on these procedures and will continue to do so when the new codes become a part of the CPT book. 58 percent of the survey respondents indicated that the vignette was typical; this rate is lower than the other codes in the pulmonary family. We believe this is again probably related to how infrequently this study is done. Ventilation only evaluation is currently limited to a very few instances where only the assessment of ventilation is needed. For example, ventilation studies may be used in the evaluation of lung transplants in the post-op period, but this usually includes a lung perfusion study as well. This would obviously be limited to the few centers which do lung transplants and is not even widely used in all centers which do lung transplants.

We compared 78579 to the reference code CPT 78306 (*Bone and/or joint imaging; whole body*) RVW 0.86 (5-8-5); while we believe these procedures are comparable, we believe the work for 78579 would require less time and less work than 78306. The SNM/ACR panel also compared 78579 to CPT 75571 (*Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium*) with an RVW of 0.58 (5-10-5) and believes these procedure's work and times are more similar.

To maintain rank order and remain within budget neutrality we recommend an RVW of 0.60 for 78579 with a pre-service time 5 minutes, intra-service time 5 minutes and post-service time 5 minutes.

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

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

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. 78593

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

CPT Code: 78580 Tracking Number L2 Original Specialty Recommended RVU: **0.74**
Presented Recommended RVU: **0.74**
Global Period: XXX RUC Recommended RVU: **0.74**

CPT Descriptor: Pulmonary perfusion imaging (eg, particulate)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Two days post-minor surgical procedure, a 60-year-old woman presents with chest pain. There is clinical concern for pulmonary embolism. A perfusion lung study, without a ventilation study, is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 62%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 2%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history, available prior imaging studies, and determines the appropriateness of the requested study, prescribes, oversees and directs the administered radiopharmaceutical dose. The physician directs the technologist to adjust the acquisition protocol, as necessary, for the individual patient. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.

Description of Intra-Service Work: Lung perfusion scintigraphy is a radionuclide diagnostic imaging study that records the distribution of pulmonary arterial blood flow within the lungs. Multiple images of the lungs are acquired. Under the supervision of the physician, the technologist administers the radiopharmaceutical. The study consists of multiple images, in multiple projections (e.g. anterior, posterior, right and left anterior & posterior obliques, right and left laterals), and documentation regarding patient position. The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views, when necessary.

The data are formatted for film and/or digital display and analysis. The physician reviews the study for artifacts and abnormal distribution. The processed and raw images (eg, upright or supine, posterior, anterior, obliques and laterals, etc.) are compared to a current chest x-ray

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician provides regulatory review and oversight throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011					
Presenter(s):	Geraldine McGinty MD, Zeke Silva MD, Gary Dillehay MD					
Specialty(s):	The American College of Radiology, The Society of Nuclear Medicine					
CPT Code:	78580					
Sample Size:	1924	Resp N:	85	Response:	4.4 %	
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		1.00	10.00	20.00	50.00	280.00
Survey RVW:		0.40	0.85	0.96	1.02	2.00
Pre-Service Evaluation Time:				7.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		1.00	5.00	10.00	15.00	45.00
Immediate Post Service-Time:		8.00				
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			
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); 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:	78580	Recommended Physician Work RVU: 0.74		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	7.00	-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:		10.00		
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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
78306	XXX	0.86	RUC Time

CPT Descriptor Bone and/or joint imaging; whole body**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78306	XXX	0.86	RUC Time	521,587

CPT Descriptor 1 Bone and/or joint imaging; whole body

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11100	000	0.81	RUC Time	2,455,457

CPT Descriptor 2 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
76830	XXX	0.69	RUC Time

CPT Descriptor Ultrasound, transvaginal**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 25 % of respondents: 29.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 78580	<u>Key Reference CPT Code:</u> 78306	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	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	20.00	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	3.00	3.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.04	2.84
--	------	------

Urgency of medical decision making	4.00	2.67
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	2.92	2.72
--------------------------	------	------

Physical effort required	2.36	2.08
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.28	2.52
---	------	------

Outcome depends on the skill and judgment of physician	3.92	3.20
--	------	------

Estimated risk of malpractice suit with poor outcome	3.88	2.84
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.48	2.12
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Intra-Service intensity/complexity	2.72	2.56
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Post-Service intensity/complexity	2.42	2.21
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Additional Rationale and Comments

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

Tab 13 Pulmonary Family

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78585 (*Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath*) was identified as a potentially misvalued code through the Harvard Valued, over 100,000 utilization

screen. The joint societies presented an action plan to the RAW to include CPTs 78580 through CPT 78596 as part of a Pulmonary (Lung) family review, with a plan to submit a CPT application in the 2012 CPT coding cycle.

The current pulmonary code family has several ventilation codes that are based on a gas versus aerosol method, and including single view and multiple view ventilation studies, which can make choosing the appropriate code difficult. Our societies believe that there is little work or cost difference between a gas and aerosol technique and recommend using the same codes, whether the ventilation portion of the study is done with a gas or with aerosolized particles. We are recommending consolidation of the codes describing the ventilation part of the study. There is also some ambiguity about the appropriate code for pulmonary function quantification, since there is currently only one pulmonary quantification code, which is used for measurement of both ventilation and perfusion. The current practice usually involves measurement of just perfusion, either regional or global and not both ventilation and perfusion. We believe this new structure of the pulmonary section simplifies the coding of these studies and will clearly address all the possible nuclear medicine lung studies currently performed.

The specialty chose to survey the entire family of pulmonary codes. We believe these procedures have not fundamentally changed over the years and condensing the current pulmonary family of 10 CPT codes into 5 new or revised pulmonary CPT codes will result in some savings to the system, while also maintaining relativity within the pulmonary family of codes, maintain relativity with other radiology codes and maintain budget neutrality.

Survey Results & SNM/ACR Recommendations:

78580

A joint SNM and ACR RVS panel (SNM/ACR) reviewed and discussed the survey results. The SNM/ACR panel was pleased that there were 85 responses to the survey request. The survey performance rate median of 20 studies per year among the 85 respondents is a reasonable rate given this procedure is not usually performed alone. Rather, it is more commonly performed in combination with a ventilation study and therefore more commonly reported with a different CPT code. We selected pre-service package 5, consistent with other nuclear medicine services, with 7 minutes of pre time and adjusted the time to our recommended value of 5 minutes of pre-time and 5 minutes of post time. The SNM/ACR panel believes the median intra-service time of 10 minutes accurately reflects the time required for this service.

We reviewed the survey median and 25 percentile of 0.96 and 0.85, respectively. The SNM/ACR panel discussed compelling evidence arguments to support the survey results. The reason for the change in coding, as noted previously, was to simplify the coding and accurately reflect the services performed. Most important for CPT 78580, we believe this procedure has not fundamentally changed over the years. Therefore, we are recommending maintaining the current RVW 0.74, even though our survey suggested a higher value is warranted. Our survey found that the reference service chosen by the survey respondents, CPT 78306 (*Bone and/or joint imaging; whole body*), (RVW 0.86), had less work intensity and complexity, when compared to the proposed CPT 78579.

Regardless, to maintain rank order and remain within budget neutrality, we recommend the current RVW of .74 for CPT 78580 with a pre service time 5 minutes, intra service time 10 minutes and post time 5 minutes.

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)

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

CPT Code: 78582 Tracking Number L3 Original Specialty Recommended RVU: **1.07**
Presented Recommended RVU: **1.07**
Global Period: XXX RUC Recommended RVU: **1.07**

CPT Descriptor: Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Shortly after an overseas airplane trip, a 53-year old man has chest pain. There is a concern for a pulmonary embolus. A ventilation and perfusion study is ordered.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 2%

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? 1%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history, available prior imaging studies, and determines the appropriateness of the requested study, prescribes, oversees and directs the administered radiopharmaceutical dose. The physician directs the technologist to adjust the acquisition protocol, as necessary, for the individual patient. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.

Description of Intra-Service Work: Lung ventilation and perfusion scintigraphy is a combination of two radionuclide diagnostic imaging procedures that record both the bronchopulmonary distribution of an inhaled radioactive aerosol or gas and the distribution of pulmonary arterial blood flow within the lungs. Multiple Images of pulmonary ventilation and perfusion are acquired and compared. Under the supervision of the physician, the technologist gives specific breathing instructions to the patient while administering the radiopharmaceuticals. The complete study consists of administration of two different radiopharmaceuticals, one by inhalation and the other by intravenous injection, acquisition of two (2) sets of multiple images in a variety of projections, (e.g. anterior, posterior, right and left anterior & posterior obliques, right and left laterals) and documentation of patient position. The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views, when necessary.

The data are formatted for film and/or digital display and analysis. The physician reviews the study for artifacts and abnormal distribution. The processed and raw images (eg, upright or supine, posterior, anterior, obliques and laterals, etc.) of both ventilation and perfusion imaging sets are compared to a current chest x-ray and any additional relevant prior studies, and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician provides regulatory review and oversight throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011					
Presenter(s):	Geraldine McGinty MD, Zeke Silva MD, Gary Dillehay MD					
Specialty(s):	The American College of Radiology, The Society of Nuclear Medicine					
CPT Code:	78582					
Sample Size:	1924	Resp N:	85	Response:	4.4 %	
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		2.00	50.00	100.00	226.25	750.00
Survey RVW:		0.75	1.00	1.07	1.30	2.20
Pre-Service Evaluation Time:				7.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		2.00	7.50	12.00	16.25	60.00
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			
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); 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:	78582	Recommended Physician Work RVU: 1.07		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	7.00	-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:		12.00		
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 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
78454	XXX	1.34	RUC Time

CPT Descriptor Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78315	XXX	1.02	RUC Time	112,370

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

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95819	XXX	1.08	RUC Time	263,080

CPT Descriptor 2 Electroencephalogram (EEG); including recording awake and asleep

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
78804	XXX	1.07	RUC Time

CPT Descriptor Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 24 % of respondents: 28.2 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 78582	<u>Key Reference CPT Code:</u> 78454	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	12.00	15.00	
Median Immediate Post-service Time	10.00	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	27.00	25.00
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	4.04	3.71
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.63
--	------	------

Urgency of medical decision making	4.58	3.88
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.74
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Physical effort required	2.61	2.70
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.08	3.92
---	------	------

Outcome depends on the skill and judgment of physician	4.58	4.25
--	------	------

Estimated risk of malpractice suit with poor outcome	4.21	4.17
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.25	2.92
----------------------------------	------	------

Intra-Service intensity/complexity	3.88	3.63
------------------------------------	------	------

Post-Service intensity/complexity	3.63	3.29
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Additional Rationale and Comments

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

Tab 13 Pulmonary Family

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78585 (*Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or*

without single breath) was identified as a potentially misvalued code through the Harvard Valued, over 100,000 utilization screen. The joint societies presented an action plan to the RAW to include CPTs 78580 through CPT 78596 as part of a Pulmonary (Lung) family review, with a plan to submit a CPT application in the 2012 CPT coding cycle.

The current pulmonary code family has several ventilation codes that are based on a gas versus aerosol method, and including single view and multiple view ventilation studies, which can make choosing the appropriate code difficult. Our societies believe that there is little work or cost difference between a gas and aerosol technique and recommend using the same codes, whether the ventilation portion of the study is done with a gas or with aerosolized particles. We are recommending consolidation of the codes describing the ventilation part of the study. There is also some ambiguity about the appropriate code for pulmonary function quantification, since there is currently only one pulmonary quantification code, which is used for measurement of both ventilation and perfusion. The current practice usually involves measurement of just perfusion, either regional or global and not both ventilation and perfusion. We believe this new structure of the pulmonary section simplifies the coding of these studies and will clearly address all the possible nuclear medicine lung studies currently performed.

The specialty chose to survey the entire family of pulmonary codes. We believe these procedures have not fundamentally changed over the years and condensing the current pulmonary family of 10 CPT codes into 5 new or revised pulmonary CPT codes will result in some savings to the system, while also maintaining relativity within the pulmonary family of codes, maintain relativity with other radiology codes and maintain budget neutrality.

Survey Results & SNM/ACR Recommendations:

78582

A joint SNM and ACR RVS panel (SNM/ACR) reviewed and discussed the survey results. CPT 78582 represents a combination of services. Two distinct and separate procedures, a pulmonary ventilation and a pulmonary perfusion study, are both performed sequentially, at the same session. This multiple study procedure is similar to other nuclear medicine procedures involving multiple studies such as planar myocardial perfusion imaging CPT 78545. The SNM/ACR panel was pleased that there were 85 responses to the survey request. The survey performance rate median of 100 studies per year among the 85 respondents is representative of the typical practice and supports the survey respondents knowledge of the procedures performed, providing additional validation to the survey results. The SNM/ACR panel agreed that the survey physician median total time of 29 minutes is appropriate for the combined two procedures. The survey median pre time 7 minutes, is appropriate. Therefore we selected pre-service package 5 with 7 minutes of pre time with no adjustment. We believe the survey median 12 minutes intra-service time and the 10 minutes of post time in total are correct. We suspect as with many of our surveys, the assignment of the allocations of where the work is done might be slightly misplaced, with respondents incorrectly placing intra-service activities into the post-service time. However the survey was strong and therefore we are recommending maintaining the survey allocations.

We believe the reference service chosen by the survey respondents CPT 78454 (*Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection*) (RVW 1.34) is a good comparison to CPT 78582. The complexity of reviewing multiple studies, along with reviewing medications and the stress test, supports the higher value RVW of 1.34, compared to our surveyed code 78582. We compared 78582 to the current value of the two highest volume CPT crosswalk codes CPT 78585 and CPT 78588, both of which have an RVW of 1.09, which supports our median survey results. This is also comparable to another multiple procedure nuclear medicine study CPT 78804 (*Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring 2 or more days imaging*), with an RVW of 1.07. As a result, the expert panel felt confident to accept the median survey results.

In summary, to maintain rank order and remain within budget neutrality, we recommend an RVW of 1.07 for 78582 with a pre service time 7 minutes, intra-service time 12 minutes and post time 10 minutes.

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.)

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

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. 78584

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

CPT Code: 78597 Tracking Number L4 Original Specialty Recommended RVU: **0.75**
Presented Recommended RVU: **0.75**
Global Period: XXX RUC Recommended RVU: **0.75**

CPT Descriptor: Quantitative differential pulmonary perfusion, including imaging when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 61-year-old man with pulmonary fibrosis has a non-small cell lung cancer for which a lobectomy is planned. There is concern for post-operative residual lung function. A quantitative perfusion lung study is ordered.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 2%

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? 2%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history, available prior imaging studies, and determines the appropriateness of the requested study, prescribes, oversees and directs the administered radiopharmaceutical dose. The physician directs the technologist to adjust the acquisition protocol, as necessary, for the individual patient. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.

Description of Intra-Service Work: Quantitative lung perfusion scintigraphy is a radionuclide diagnostic imaging study that records the relative distribution of pulmonary arterial blood flow in each lung (left, right), and within comparable areas within each lung (eg, upper, middle and lower thirds). Under the supervision of the physician, the technologist administers the radiopharmaceutical. The study consists of acquisition of timed imaging data from both the anterior and posterior projections, and may include comparable lateral projections. Measurements of relative radioactivity are made and the results expressed as percentages of the whole. The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views or re-process data, when necessary.

The data are formatted for film and/or digital display and analysis. The physician reviews the study for artifacts and abnormal distribution. Quantitative evaluation of the images, including but not limited to anterior, posterior and the geometric mean(s) for global and regional perfusion is/are calculated and recorded. The processed and raw images when performed (eg, upright or supine, posterior, anterior, etc.) are compared to a current chest x-ray and any additional relevant prior studies, and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician provides regulatory review and oversight throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011				
Presenter(s):	Geraldine McGinty MD, Zeke Silva MD, Gary Dillehay MD				
Specialty(s):	The American College of Radiology, The Society of Nuclear Medicine				
CPT Code:	78597				
Sample Size:	1924	Resp N:	58	Response: 3.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		1.00	7.50	15.00	31.50
Survey RVW:		0.41	0.80	0.96	1.04
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	10.00	14.25
Immediate Post Service-Time:		8.00			
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		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 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); 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:	78597	Recommended Physician Work RVU: 0.75		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	7.00	-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:		10.00		
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	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
78306	XXX	0.86	RUC Time

CPT Descriptor Bone and/or joint imaging; whole body**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78306	XXX	0.86	RUC Time	521,587

CPT Descriptor 1 Bone and/or joint imaging; whole body

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11100	000	0.00	RUC Time	2,455,457

CPT Descriptor 2 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
76817	XXX	0.75	RUC Time

CPT Descriptor Ultrasound, pregnant uterus, real time with image documentation, transvaginal**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 18.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 78597	<u>Key Reference CPT Code:</u> 78306	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	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	20.00	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	2.40	2.73
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.36	2.73
Urgency of medical decision making	1.91	2.45

Technical Skill/Physical Effort (Mean)

Technical skill required	2.20	2.60
--------------------------	------	------

Physical effort required	2.00	2.40
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	2.36
---	------	------

Outcome depends on the skill and judgment of physician	2.55	2.82
--	------	------

Estimated risk of malpractice suit with poor outcome	2.27	2.27
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.36	2.64
----------------------------------	------	------

Intra-Service intensity/complexity	2.27	2.55
------------------------------------	------	------

Post-Service intensity/complexity	2.64	2.82
-----------------------------------	------	------

Additional Rationale and Comments

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

Tab 13 Pulmonary Family

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78585 (*Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or*

without single breath) was identified as a potentially misvalued code through the Harvard Valued, over 100,000 utilization screen. The joint societies presented an action plan to the RAW to include CPTs 78580 through CPT 78596 as part of a Pulmonary (Lung) family review, with a plan to submit a CPT application in the 2012 CPT coding cycle.

The current pulmonary code family has several ventilation codes that are based on a gas versus aerosol method, and including single view and multiple view ventilation studies, which can make choosing the appropriate code difficult. Our societies believe that there is little work or cost difference between a gas and aerosol technique and recommend using the same codes, whether the ventilation portion of the study is done with a gas or with aerosolized particles. We are recommending consolidation of the codes describing the ventilation part of the study. There is also some ambiguity about the appropriate code for pulmonary function quantification, since there is currently only one pulmonary quantification code, which is used for measurement of both ventilation and perfusion. The current practice usually involves measurement of just perfusion, either regional or global and not both ventilation and perfusion. We believe this new structure of the pulmonary section simplifies the coding of these studies and will clearly address all the possible nuclear medicine lung studies currently performed.

The specialty chose to survey the entire family of pulmonary codes. We believe these procedures have not fundamentally changed over the years and condensing the current pulmonary family of 10 CPT codes into 5 new or revised pulmonary CPT codes will result in some savings to the system, while also maintaining relativity within the pulmonary family of codes, maintain relativity with other radiology codes and maintain budget neutrality.

Survey Results & SNM/ACR Recommendations:

78597

A joint SNM and ACR RVS panel (SNM/ACR) reviewed and discussed the survey results. The SNM/ACR panel was pleased that there were 58 responses to the survey request. The survey performance rate median of 15 studies per year among the 58 respondents is expected as this is a relatively low volume procedure. We selected pre-service package 5, consistent with other nuclear medicine services, with 7 minutes of pre time and adjusted the time to our recommended value of 5 minutes of pre-time and 5 minutes of post time. The SNM/ACR panel believes the median intra-service time of 10 minutes accurately reflects the time required for this service.

We reviewed the survey median and 25 percentile RVW of 0.96 and 0.80, respectively. Our expert panel considered the varying ranges regarding providers' level of work for these procedures. We concede that some studies may require a significantly higher level of work than others due to the expectations of different referring physicians. However in our expert panels' opinion, the typical study is not of greater work than the non-quantitative, diagnostic pulmonary imaging studies.

We believe that the current code CPT 78596 was not appropriately ranked relative to other nuclear medicine procedures. The current CPT 78596 (*Pulmonary quantitative differential function (ventilation/perfusion) study*) has an RVW of 1.27, with a total of 22 minutes. This is higher than any of the single or multiple pulmonary ventilation or perfusion study codes.

We also compared CPT 78597 to 76817 (*Ultrasound, pregnant uterus, real time with image documentation, transvaginal*) RVW 0.75 (5-10-8) and found them comparable in work and time.

In summary, to maintain rank order and maintain budget neutrality we recommend an RVW of 0.75, which is below the 25th percentile, with a pre service time 5 minutes, intra service time 10 minutes and post time 5 minutes.

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.

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

CPT Code:78598 Tracking Number L5

Original Specialty Recommended RVU: **0.85**

Global Period: XXX

Presented Recommended RVU: **0.85**RUC Recommended RVU: **0.85**

CPT Descriptor: Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old woman with chronic obstructive pulmonary disease is scheduled to have surgery for a non-small cell lung cancer. There is concern for post-operative residual lung function. A quantitative perfusion and ventilation study is ordered.

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 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the reason for the exam, pertinent clinical history, available prior imaging studies, and determines the appropriateness of the requested study, prescribes, oversees and directs the administered radiopharmaceutical dose. The physician directs the technologist to adjust the acquisition protocol, as necessary, for the individual patient. The physician is available to answer questions for the technologist, review components of the study and provide regulatory oversight throughout the procedure.

Description of Intra-Service Work: Quantitative lung ventilation and perfusion scintigraphy is a combination of two radionuclide diagnostic imaging studies that measure the bronchopulmonary distribution of an inhaled radioactive aerosol or gas and the relative distribution of pulmonary arterial blood flow in each lung (left, right) and within comparable areas within each lung (eg, upper, middle and lower thirds). Under the supervision of the physician, the technologist gives specific breathing instructions to the patient while administering the radiopharmaceuticals. The study consists of multiple acquisitions of timed imaging data from both the anterior and posterior projections, and may include comparable lateral projections. Measurements of relative radioactivity are made and the results expressed as percentages of the whole. The physician verifies the adequacy of the imaging data before completion of the study, and directs the technologist to obtain additional views or re-process data, when necessary.

The data are formatted for film and/or digital display and analysis. The physician reviews the study for artifacts and abnormal distribution. Quantitative evaluation of the images, including but not limited to anterior, posterior and the geometric mean(s) for global and regional perfusion is/are calculated and recorded. The processed and raw images when

performed (eg, upright or supine, posterior, etc.) are compared to a current chest x-ray and any additional relevant prior studies, and formally interpreted, i.e., a report is dictated for the medical record.

Description of Post-Service Work: The physician reviews and signs the report for the medical record. The imaging results are discussed with the referring physician and may be discussed with the patient and family. The physician provides regulatory review and oversight throughout the procedure.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011				
Presenter(s):	Geraldine McGinty MD, Zeke Silva MD, Gary Dillehay MD				
Specialty(s):	The American College of Radiology, The Society of Nuclear Medicine				
CPT Code:	78598				
Sample Size:	1924	Resp N:	59	Response: 3.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		1.00	5.00	15.00	37.50
Survey RVW:		0.50	0.85	1.04	2.40
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	6.75	10.00	15.00
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		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 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); 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:	78598	Recommended Physician Work RVU: 0.85		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	7.00	-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:		10.00		
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 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
78454	XXX	1.34	RUC Time

CPT Descriptor Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78306	XXX	0.86	RUC Time	521,587

CPT Descriptor 1 Bone and/or joint imaging; whole body

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11100	000	0.81	RUC Time	2,455,457

CPT Descriptor 2 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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: 11 % of respondents: 18.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 78598	<u>Key Reference CPT Code:</u> 78454	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	10.00	15.00	
Median Immediate Post-service Time	9.00	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	24.00	25.00
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	2.91	3.27
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.45	3.64
--	------	------

Urgency of medical decision making	2.73	3.73
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	3.55
--------------------------	------	------

Physical effort required	2.36	2.18
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.09	3.73
---	------	------

Outcome depends on the skill and judgment of physician	3.73	3.82
--	------	------

Estimated risk of malpractice suit with poor outcome	2.73	4.09
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.73	3.09
----------------------------------	------	------

Intra-Service intensity/complexity	3.64	3.45
------------------------------------	------	------

Post-Service intensity/complexity	2.91	3.18
-----------------------------------	------	------

Additional Rationale and Comments

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

Tab 13 Pulmonary Family

As a result of the RUC Relativity Assessment Workgroup (RAW), formerly the Five-Year Review Identification Workgroup, CPT 78585 (*Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or*

without single breath) was identified as a potentially misvalued code through the Harvard Valued, over 100,000 utilization screen. The joint societies presented an action plan to the RAW to include CPTs 78580 through CPT 78596 as part of a Pulmonary (Lung) family review, with a plan to submit a CPT application in the 2012 CPT coding cycle.

The current pulmonary code family has several ventilation codes that are based on a gas versus aerosol method, and including single view and multiple view ventilation studies, which can make choosing the appropriate code difficult. Our societies believe that there is little work or cost difference between a gas and aerosol technique and recommend using the same codes, whether the ventilation portion of the study is done with a gas or with aerosolized particles. We are recommending consolidation of the codes describing the ventilation part of the study. There is also some ambiguity about the appropriate code for pulmonary function quantification, since there is currently only one pulmonary quantification code, which is used for measurement of both ventilation and perfusion. The current practice usually involves measurement of just perfusion, either regional or global and not both ventilation and perfusion. We believe this new structure of the pulmonary section simplifies the coding of these studies and will clearly address all the possible nuclear medicine lung studies currently performed.

The specialty chose to survey the entire family of pulmonary codes. We believe these procedures have not fundamentally changed over the years and condensing the current pulmonary family of 10 CPT codes into 5 new or revised pulmonary CPT codes will result in some savings to the system, while also maintaining relativity within the pulmonary family of codes, maintain relativity with other radiology codes and maintain budget neutrality.

Survey Results & SNM/ACR Recommendations:

78598

A joint SNM and ACR RVS panel (SNM/ACR) reviewed and discussed the survey results. The SNM/ACR panel was pleased that there were 59 responses to the survey request. The survey performance rate median of 15 studies per year among the 59 respondents is expected as this is a relatively low volume procedure. We selected pre-service package 5, consistent with other nuclear medicine services, with 7 minutes of pre time and adjusted the time to our recommended value of 5 minutes of pre-time. We believe the survey median of 10 minutes intra-service time and 9 minutes of post-service time in total are correct. We suspect, as with many of our surveys, the assignment of the allocation of where the work is done, confusing intra-service time with post-service time, probably artificially raises the post-service times. Regardless, the panel is recommending the survey median time and allocations.

We reviewed the RVW survey median and 25 percentile RVW values of 1.04 and 0.84 respectively. Our expert panel considered the varying ranges regarding the effect referring physician's expectations have on the level of work necessary for these procedures. The variations in level of work found on the survey may be the result of some referring physicians requiring some providers to provide more detailed reports and analysis of the data obtained from these studies. This is the result of differing indications for the quantitation data and different applications of the resulting data (i.e. lung reduction surgical candidates for COPD vs. patients referred only to evaluate for possible pneumonectomy.) In our expert panels' opinion, the typical study is not of greater work than the non-quantitative diagnostic pulmonary imaging studies.

We believe that the current code CPT 78596 was not appropriately ranked relative to other nuclear medicine procedures. The current CPT 78596 (*Pulmonary quantitative differential function (ventilation/perfusion) study*) has an RVW of 1.27, with a total of 22 minutes. This is higher than any of the single or multiple pulmonary ventilation or perfusion study codes.

We believe the reference service code chosen by the survey respondents CPT 78454 (*Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection*) (RVW 1.34) has more work intensity and complexity than the new multiple quantitation pulmonary perfusion CPT 78598. We also compared CPT 78598 to MPC code CPT 78306 (*Bone and/or joint imaging; whole body*) RVW 0.86 (5-8-5) and CPT 76700 (*Ultrasound, abdominal, real time with image documentation; complete*) RVW 0.81 (3-10-4) and believe that both are comparable in work and service times.

In summary, to maintain rank order and remain within budget neutrality we recommend the 25th percentile RVW of 0.85 with a pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 9 minutes.

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) 78796

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 Pulmonary How often? Sometimes

Specialty Radiology How often? Sometimes

Specialty Pulmonary How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 25989

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Used RUC data as basis

Specialty Pulmonary Frequency 10000 Percentage 38.47 %

Specialty Radiology Frequency 10000 Percentage 38.47 %

Specialty Nuclear Medicine Frequency 5989 Percentage 23.04 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 8,663

If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Used RUC data as basis

Specialty Pulmonary Frequency 4000 Percentage 46.17 %

Specialty Radiology Frequency 4000 Percentage 46.17 %

Specialty Nuclear Medicine Frequency 4000 Percentage 46.17 %

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

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. 78596

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

CPT Long Descriptor:

Pulmonary ventilation imaging (eg, aerosol or gas)

Global Period: XXX

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

We convened a joint SNM and ACR expert panel with varying geographic regions and varying experiences.

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

We have included the current CMS PE inputs for CPT 78580 *Pulmonary perfusion imaging, particulate* and CPT 78585 *Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath* CPT 78588 *Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, 1 or multiple projections* and CPT 78596 *Pulmonary quantitative differential function (ventilation/perfusion) study*. These CPT codes have similar inputs and are the highest volume perfusion or ventilation and perfusion imaging studies. For clarification, one column lists three CPT codes, those inputs were similar with the exception of a very few items. Those items if different will be presented respectively with a space in between to save space and reduce the number of comparison columns.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review x-ray, lab and past test to confirm appropriates with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy
- QC Planar Equipment
- Prepare radiopharmaceutical (RP) (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of vial, and recording all regulatory required documentation. Ready dose for administration with in-house labels and records.

Intra-Service Clinical Labor Activities:

- Greet patient and provide gowning
- Review mandatory radiation education; verbal consent
- Prepare room, equipment, supplies, change collimator and set up protocol
- Position patient/ monitor patient

- Obtain from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)
- Explain ventilation procedure to patient; administration of RP
- Acquire images and review for completeness, quality, and time
- Instruction/Counseling as patient is taken back to waiting area with an emphasis on radiation risk to those at home.
- Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient

Post-Service Clinical Labor Activities:

- Clean room/equipment by physician staff
- Specific room clean up of RP administration areas with defacement of labels
- Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.

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

CPT Long Descriptor:

Pulmonary perfusion imaging (eg, particulate)

Global Period: XXX

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

We convened a joint SNM and ACR expert panel with varying geographic regions and varying experiences.

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 the current CMS PE inputs for CPT 78580 *Pulmonary perfusion imaging, particulate* and CPT 78585 *Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath* CPT 78588 *Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, 1 or multiple projections* and CPT 78596 *Pulmonary quantitative differential function (ventilation/perfusion) study*. These CPT codes have similar inputs and are the highest volume perfusion or ventilation and perfusion imaging studies. For clarification, one column lists three CPT codes, those inputs were similar with the exception of a very few items. Those items if different will be presented respectively with a space in between to save space and reduce the number of comparison columns.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review x-ray, lab and past test to confirm appropriates with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy
- QC Planar Equipment
- Prepare radiopharmaceutical (RP) (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.

Intra-Service Clinical Labor Activities:

- Greet patient and provide gowning
- Review mandatory radiation education; verbal consent
- Prepare room, equipment, supplies, change collimator and set up protocol
- Position patient/ monitor patient

- Obtain from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)
- Placement of IV; administration of RP
- Acquire images and review for completeness, quality, and time
- Instruction/Counseling as patient is taken back to waiting area after each scanning session with an emphasis on radiation risk to those at home.
- Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient

Post-Service Clinical Labor Activities:

- Clean room/equipment by physician staff
- Specific room clean up of RP injection areas with defacement of labels
- Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.

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

CPT Long Descriptor:

Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging

Global Period: XXX

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

We convened a joint SNM and ACR expert panel with varying geographic regions and varying experiences.

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 the current CMS PE inputs for CPT 78580 *Pulmonary perfusion imaging, particulate* and CPT 78585 *Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath* CPT 78588 *Pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, 1 or multiple projections* and CPT 78596 *Pulmonary quantitative differential function (ventilation/perfusion) study*. These CPT codes have similar inputs and are the highest volume perfusion or ventilation and perfusion imaging studies. For clarification, one column lists three CPT codes, those inputs were similar with the exception of a very few items. Those items if different will be presented respectively with a space in between to save space and reduce the number of comparison columns.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review x-ray, lab and past test to confirm appropriates with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical(s) dose, and order radiopharmaceutical(s) from central/commercial nuclear pharmacy
- QC Planar Equipment
- Prepare radiopharmaceutical(s) (RP) (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RPs, survey, package, wipe test of syringe and vial, and recording all regulatory required documentation. Ready doses for potential injection or administration with in-house labels and records.

Intra-Service Clinical Labor Activities:

- Greet patient and provide gowning
- Review mandatory radiation education; verbal consent
- Prepare room, equipment, supplies, change collimator and set up protocols
- Position patient/ monitor patient

- Obtain from RPs storage/preparation area, recheck doses, record, reassay, and ensure doses would be appropriate (following protocols) based on the written directive (correct test and patient weight)
- Placement of IV; instruct patient regarding ventilation apparatus, administration of RPs
- Acquire images and review for completeness, quality, and time
- Instruction/Counseling as patient is taken back to waiting area after scanning session with an emphasis on radiation risk to those at home.
- Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient

Post-Service Clinical Labor Activities:

- Clean room/equipment by physician staff
- Specific room clean up of RP injection or ventilation administration areas with defacement of labels
- Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.

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

CPT Long Descriptor:

Quantitative differential pulmonary perfusion, including imaging when performed

Global Period: XXX

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

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Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

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- QC Planar Equipment
- Prepare radiopharmaceutical (RP) (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.

Intra-Service Clinical Labor Activities:

- Greet patient and provide gowning
- Review mandatory radiation education; verbal consent
- Prepare room, equipment, supplies, change collimator and set up protocol
- Position patient/ monitor patient

- Obtain from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)
- Placement of IV; administration of RP
- Acquire images and review for completeness, quality, and time
- Instruction/Counseling as patient is taken back to waiting area after each scanning session with an emphasis on radiation risk to those at home.
- Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient

Post-Service Clinical Labor Activities:

- Clean room/equipment by physician staff
- Specific room clean up of RP injection areas with defacement of labels
- Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.

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

CPT Long Descriptor:

Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed

Global Period: XXX

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

We convened a joint SNM and ACR expert panel with varying geographic regions and varying experiences.

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

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Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- Review x-ray, lab and past test to confirm appropriates with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical(s) dose, and order radiopharmaceutical(s) from central/commercial nuclear pharmacy
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Intra-Service Clinical Labor Activities:

- Greet patient and provide gowning
- Review mandatory radiation education; verbal consent
- Prepare room, equipment, supplies, change collimator and set up protocols
- Position patient/ monitor patient

- Obtain from RPs storage/preparation area, recheck doses, record, reassay, and ensure doses would be appropriate (following protocols) based on the written directive (correct test and patient weight)
- Placement of IV; instruct patient regarding ventilation apparatus, administration of RPs
- Acquire images and review for completeness, quality, and time
- Instruction/Counseling as patient is taken back to waiting area after scanning session with an emphasis on radiation risk to those at home.
- Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient

Post-Service Clinical Labor Activities:

- Clean room/equipment by physician staff
- Specific room clean up of RP injection or ventilation administration areas with defacement of labels
- Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.

	A	B	C	D	E	F	G	H
1	AMA/Specialty Society RVS Update Committee Recommendation			▲ 78580	78597	78582	78598	78579
2	Meeting Date: January - February 2011 Pulmonary (Lung) Family	CMS	Staff	▲ Pulmonary perfusion imaging, particulate (eg, particulate)	Quantitative differential pulmonary perfusion, including imaging when performed	Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging	Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed	Pulmonary ventilation imaging (eg, aerosol or gas)
3		Code	Type	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
4				XXX	XXX	XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME	L049A	NMT	83.0	83.0	123.0	120.0	83.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L049A	NMT	20.0	20.0	20.0	20.0	20.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L049A	NMT	63.0	63.0	103.0	100.0	63.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L049A	NMT	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	Review x-ray, lab and past test to confirm appropriateness with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy	L049A	NMT	3	3	3	3	3
12	QC Planar Equipment	L049A	NMT	4	4	4	4	4
13	Prepare radiopharmaceutical (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.	L049A	NMT	13	13	13	13	13
14	End: When patient enters office/facility for surgery/procedure	L049A						
15	SERVICE PERIOD							
16	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure							
17	Greet patient and provide gowning	L049A	NMT	3	3	3	3	3
18	Review mandatory radiation education; verbal consent	L049A	NMT	3	3	3	3	3
19	Prepare room, equipment, supplies, change collimator and set up protocol	L049A	NMT	2	2	2	2	2
20	Intra-service	L049A						
21	Position patient/ monitor patient/ set up any flow imaging	L049A	NMT	2	2	2	2	2
22	Instruction/Counseling as patient is taken back to waiting area after each scanning session	L049A	NMT	0	0	0	0	0
23	Obtain RP & or Pharm Intervention from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)	L049A	NMT	5	5	10	10	5
24	Placement of IV/admin RP; tech present during injection of RP and if appropriate Pharm intervention	L049A	NMT	5	5	7	7	5
25	Acquire images and review for completeness and quality, and time	L049A	NMT	30	20	50	45	20
26	Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient	L049A	NMT	7	7	10	12	7
27	Post-Service	L049A						
28	Clean room/equipment by physician staff	L049A	NMT	3	3	3	3	3
29	Specific room clean up of RP injection areas with defacement of labels	L049A	NMT	4	4	4	4	4
30	Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.	L049A	NMT	3	3	3	3	3
31	End: Patient leaves office	L049A						
32	POST-SERVICE Period							
33	None							
34	MEDICAL SUPPLIES		Unit					
35	drape, non-sterile, sheet 40in x 60in	SB006		2	2	2	2	2
36	Non-sterile gloves	SB022		1	2	2	2	1
37	underpad 2ft x 3ft (Chux)	SB044		1	1	2	2	1
38	angiocatheter 14g-24g	SC001		1	1	1	1	0
39	heparin lock	SC012		1	1	1	1	0
40	needle, 18-27g	SC029		1	1	2	2	1
41	stop cock, 3-way	SC049		1	1	1	1	0
42	syringe 10-12ml	SC051		1	1	2	2	1
43	sanitizing cloth-wipe (surface, instruments, equipment)	SM022		5	5	10	10	5
44	pack, minimum multi-specialty visit	SA048		1	1	2	2	1
45	film, x-ray 8in x 10in	SK037		2	2	4	4	1
46	x-ray envelope	SK091		1	1	1	1	1
47	x-ray fixer solution	SK092		2	2	4	4	2
48	swab-pad, alcohol	SJ053		2	2	4	4	1

Pulmonary

	A	B	C	D	E	F	G	H
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49	heparin lock flush soln	SH040		1	1	1	1	0
50	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068		1	1	1	1	0
51	bandage, strip 0.75in x 3in (Bandaid)	SG021		1	1	1	1	0
52	gauze, non-sterile 2in x 2in	SG050		1	1	1	1	1
53	Equipment							
54	Cobalt-57 Flood Source (47cm dia) (10 mCi)	ER001		4	4	4	4	4
55	computer workstation, nuclear medicine analysis	ED019		10	15	10	20	10
56	computer workstation, nuclear pharmacy management (hardware and software)	ED020		24	24	29	29	24
57	Film processor, wet	ED025		5	5	10	10	5
58	dose calibration source vial set (Cs137, Co57, and Ba137)	ER026		16	16	16	16	16
59	dose calibrator (Atomlab)	ER027		28	28	33	33	28
60	gamma camera system, single-dual head	ER032		48	38	71	68	38
61	radiation L-block tabletop shield	ER053		28	28	33	33	28
62	radiation survey meter	ER054		20	20	20	20	20
63	safe, storage, lead-lined	ER058		28	28	33	33	28
64	x-ray view box, 4 panel	ER067		10	10	15	15	10
65	Radioaerosol Administration System	Invoice		0 min	0 min	10	10	10

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2	Meeting Date: January - February 2011 Pulmonary (Lung) Family	CMS	Staff	▲ Pulmonary perfusion imaging, particulate (eg, particulate)	Quantitative differential pulmonary perfusion, including imaging when performed	Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging	Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed	Pulmonary ventilation imaging (eg, aerosol or gas)
3		Code	Type	Non Facility	Non Facility	Non Facility	Non Facility	Non Facility
4				XXX	XXX	XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME	L049A	NMT	97.0	87.0	129.0	126.0	87.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L049A	NMT	20.0	20.0	20.0	20.0	20.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L049A	NMT	64.0	54.0	96.0	93.0	54.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L049A	NMT	13.0	13.0	13.0	13.0	13.0
9	PRE-SERVICE							
10	Start: Following visit when decision for surgery or procedure made							
11	Review x-ray, lab and past test to confirm appropriateness with physician, confirm technique to be used, obtain physician written directive, determine radiopharmaceutical dose, and order radiopharmaceutical from central/commercial nuclear pharmacy	L049A	NMT	3	3	3	3	3
12	QC Planar Equipment	L049A	NMT	4	4	4	4	4
13	Prepare radiopharmaceutical (prepare and QC dose) delivered by central/commercial nuclear pharmacy with NRC required check-in of RP, survey, package, wipe test of syringe, and recording all regulatory required documentation. Ready dose for potential injection with in-house labels and records.	L049A	NMT	13	13	13	13	13
14	End: When patient enters office/facility for surgery/procedure	L049A						
15	SERVICE PERIOD							
16	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure							
17	Greet patient and provide gowning	L049A	NMT	3	3	3	3	3
18	Review mandatory radiation education; verbal consent	L049A	NMT	3	3	3	3	3
19	Prepare room, equipment, supplies, change collimator and set up protocol	L049A	NMT	3	3	3	3	3
20	Intra-service	L049A						
21	Position patient/ monitor patient/ set up any flow imaging	L049A	NMT	5	5	7	7	5
22	Instruction/Counseling as patient is taken back to waiting area after each scanning session	L049A	NMT	3	3	3	3	3
23	Obtain RP & or Pharm Intervention from RP storage/preparation area, recheck dose, record, reassay, and ensure dose would be appropriate (following protocols) based on the written directive (correct test and patient weight)	L049A	NMT	5	5	10	10	5
24	Placement of IV/admin RP; tech present during injection of RP and if appropriate Pharm intervention	L049A	NMT	5	5	7	7	5
25	Acquire images and review for completeness and quality, and time	L049A	NMT	30	20	50	45	20
26	Complete diagnostic forms, lab & X-ray requisitions, image processing, development hard copy, archive and obtain approval to discharge patient	L049A	NMT	7	7	10	12	7
27	Post-Service	L049A						
28	Clean room/equipment by physician staff	L049A	NMT	3	3	3	3	3
29	Specific room clean up of RP injection areas with defacement of labels	L049A	NMT	5	5	5	5	5
30	Regulatory compliance - NRC required wipe tests and survey areas used including regulatory documentation.	L049A	NMT	5	5	5	5	5
31	End: Patient leaves office	L049A						
32	POST-SERVICE Period							
33	None							
34	MEDICAL SUPPLIES		Unit					
35	drape, non-sterile, sheet 40in x 60in	SB006		2	2	2	2	2
36	Non-sterile gloves	SB022		1	2	2	2	1
37	underpad 2ft x 3ft (Chux)	SB044		1	1	2	2	1
38	angiocatheter 14g-24g	SC001		1	1	1	1	0
39	heparin lock	SC012		1	1	1	1	0
40	needle, 18-27g	SC029		1	1	2	2	1
41	stop cock, 3-way	SC049		1	1	1	1	0
42	syringe 10-12ml	SC051		1	1	2	2	1
43	sanitizing cloth-wipe (surface, instruments, equipment)	SM022		5	5	10	10	5
44	pack, minimum multi-specialty visit	SA048		1	1	2	2	1
45	film, x-ray 8in x 10in	SK037		2	2	4	4	1
46	x-ray envelope	SK091		1	1	1	1	1
47	x-ray fixer solution	SK092		2	2	4	4	2
48	swab-pad, alcohol	SJ053		2	2	4	4	1

Pulmonary

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49	heparin lock flush soln	SH040		1	1	1	1	0
50	sodium chloride 0.9% inj bacteriostatic (30ml uou)	SH068		1	1	1	1	0
51	bandage, strip 0.75in x 3in (Bandaid)	SG021		1	1	1	1	0
52	gauze, non-sterile 2in x 2in	SG050		1	1	1	1	1
53	Equipment							
54	Cobalt-57 Flood Source (47cm dia) (10 mCi)	ER001		4	4	4	4	4
55	computer workstation, nuclear medicine analysis	ED019		10	15	10	20	10
56	computer workstation, nuclear pharmacy management (hardware and software)	ED020		26	26	31	31	26
57	Film processor, wet	ED025		5	5	10	10	5
58	dose calibration source vial set (Cs137, Co57, and Ba137)	ER026		16	16	16	16	16
59	dose calibrator (Atomlab)	ER027		31	31	36	36	31
60	gamma camera system, single-dual head	ER032		52	42	77	74	42
61	radiation L-block tabletop shield	ER053		31	31	36	36	31
62	radiation survey meter	ER054		23	23	23	23	23
63	safe, storage, lead-lined	ER058		31	31	36	36	31
64	x-ray view box, 4 panel	ER067		10	10	15	15	10
65	Radioaerosol Administration System	Invoice		0 min	0 min	10	10	10

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2011

Molecular Pathology-Tier 1

The CPT Editorial Panel has developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. In October 2010 and February 2011, the Panel accepted 92 Tier 1 codes, which are a list of gene-specific and genomic analysis CPT codes for high-volume molecular pathology services. These services were previously reported with a series of “stacking codes.” The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS has requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information as a policy is developed to determine which payment schedule is appropriate for these services. In April 2011, the specialty presented information on 18 Tier I codes, with the intent to provide data on additional 52 services in September 2011. At this time, the specialty indicated that physician interpretation is not typically required for the remaining 22 Tier I codes.

81206 BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative

A survey of 62 pathologists indicated that the median time for 81206 was 15 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the work is similar to 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work RVU = 0.37). **The RUC recommends a work RVU of 0.37 for CPT code 81206.**

81207 BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative

A survey of 30 pathologists indicated that the median time for 81207 was 11 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the work is slightly more work and reflects higher intensity than 88302 Level II – *Surgical pathology, gross and microscopic examination* (time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81207.**

81208 BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative

A survey of 16 pathologists indicated that the median time for 81208 was 18 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.46. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that a work RVU of 0.46 accurately values this service relative to 81206 and 81207. In addition, 81208 requires slightly more physician work and time to perform compared to 88141 *Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician* (total time = 16 minutes, work = 0.42). **The RUC recommends a work RVU of 0.46 for CPT code 81208.**

81220 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)

A survey of 32 pathologists indicated that the median time for 81220 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that 81220 requires slightly more work to perform and is more intense than 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81220.**

81221 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants

A survey of 13 pathologists indicated that the median time for 81221 was 20 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.40. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that a work RVU of 0.40 appropriately values this service relative to 81220 and 81222. In addition, 81221 requires less work and intensity to perform compared to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work = 0.52). **The RUC recommends a work RVU of 0.40 for CPT code 81221.**

81222 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants

A survey of 6 pathologists indicated that the median time for 81222 was 13 minutes and reflects a median work RVU of 0.22. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81222 to 88304 *Level III Surgical pathology, gross and microscopic examination* (total time = 15 minutes, work = 0.22) and determined the physician work required to perform these services are equal. The RUC recommends the physician work for 81222 be crosswalked to 88304. In addition the RUC agreed that a work RVU of 0.22 places this service in the proper rank order relative to 81220 and 81221. **The RUC recommends a work RVU of 0.22 for CPT code 81222.**

81223 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence

A survey of 9 pathologists indicated that the median time for 81223 was 20 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that a work RVU of 0.40 is appropriate as 81223 requires the same physician work to perform as 81221. In addition, 81223 requires less physician work and intensity to perform compared to 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work = 0.52), therefore places the surveyed service in the proper rank order. **The RUC recommends a work RVU of 0.40 for CPT code 81223.**

81224 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)

A survey of 14 pathologists indicated that the median time for 81224 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC agreed with the specialty that 81224 requires slightly more physician work to perform and is more intense compared to 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81224.**

81240 F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant

A survey of 42 pathologists indicated that the median time for 81240 was 7 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the physician work required to perform 81240 is equivalent to 88302 Level II *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13) and should be crosswalked. **The RUC recommends a work RVU of 0.13 for CPT code 81240.**

81241 F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis; Leiden variant

A survey of 41 pathologists indicated that the median time for 81241 was 8 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the physician work required to perform 81241 is equivalent to 88302 Level II *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13) and should be crosswalked. **The RUC recommends a work RVU of 0.13 for CPT code 81241.**

81243 FMRI (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles

A survey of 13 pathologists indicated that the median time for 81243 was 15 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.37. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 900 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81243 to 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work = 0.37) and determined 81243 requires the same physician work to perform, which is supported by the survey 25th percentile work RVU of 0.37. **The RUC recommends a work RVU of 0.37 for CPT code 81243.**

81244 FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)

A survey of 11 pathologists indicated that the median time for 81244 was 20 minutes and the specialty recommended work value reflects a 25th percentile work RVU of 0.51. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 100 annually in the Medicare population) and few pathologists are currently performing this test. However, the RUC agreed that work RVU of 0.51 appropriately values this service relative to the work and intensity of 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work RVU = 0.52). **The RUC recommends a work RVU of 0.51 for CPT code 81244.**

81256 HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)

A survey of 18 pathologists indicated that the median time for 81256 was 7 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that the physician work is equivalent to 88302 *Level II Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13) and therefore should be crosswalked. **The RUC recommends a work RVU of 0.13 for CPT code 81256.**

81270 JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis; V617F variant

A survey of 46 pathologists indicated that the median time for 81270 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC agreed with the specialty that 81270 requires slightly more physician work and is more intense to perform compared to 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81270.**

81275 KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis; variants in codons 12 and 13

A survey of 43 pathologists indicated that the median time for 81275 was 20 minutes and reflects a 25th percentile work RVU of 0.50. The RUC agreed that survey 25th percentile work RVU of 0.50 appropriately values this service relative to the work and intensity required to perform 88291 *Cytogenetics and molecular cytogenetics, interpretation and report* (total time = 20 minutes, work = 0.52). **The RUC recommends a work RVU of 0.50 for CPT code 81275.**

81291 MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)

A survey of 16 pathologists indicated that the median time for 81291 was 10 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 5,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC agreed with the specialty that 81291 requires slightly more physician work to perform than 88302 Level II – *Surgical pathology, gross and microscopic examination* (total time = 11 minutes, work RVU = 0.13). **The RUC recommends a work RVU of 0.15 for CPT code 81291.**

81315 PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative

A survey of 27 pathologists indicated that the median time for 81243 was 15 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81315 to 86320 *Immunoelectrophoresis; serum* (total time = 17 minutes, work = 0.37) and determined that the surveyed code requires the same physician work to perform and therefore should be crosswalked. **The RUC recommends a work RVU of 0.37 for CPT code 81315.**

81316 PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative

A survey of 15 pathologists indicated that the median time for 81316 was 12 minutes, however, the specialty recommended that the work valuation was overstated by these respondents. The RUC noted that less than 30 pathologists responded to the survey for this code. This code is rarely performed (estimated 1,000 annually in the Medicare population) and few pathologists are currently performing this test. The RUC compared 81316 to 88304 *Level III Surgical pathology, gross and microscopic examination* (total time = 15 minutes, work = 0.22) and determined that the surveyed code requires the same physician work to perform and therefore should be crosswalked. **The RUC recommends a work RVU of 0.22 for 81316.**

Practice Expense

The specialty provided data based on assumed batch sizes and modified these batch size estimates to ensure maximum efficiency for today's practice. However, these assumptions should be re-examined when greater experience is available for these services.

Work Neutrality

Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology

The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The time, work valuation, and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
Pathology and Laboratory Molecular Pathology				
<p><u>Molecular pathology procedures are medical laboratory procedures involving the analyses of nucleic acid to detect variants in genes that may be indicative of germline (eg, constitutional disorders) or somatic (eg, neoplasia) conditions, or to test for histocompatibility antigens (eg, HLA). Code selection is typically based on the specific gene(s) that is being analyzed. Genes are described using Human Genome Organization (HUGO) approved gene names and are italicized in the code descriptors. When the gene name is represented by an abbreviation, the abbreviation is listed first, followed by the full gene name italicized in parentheses (eg, “F5 [<i>coagulation Factor V</i>]”), except for the HLA series of codes. Proteins or diseases commonly associated with the genes are listed as examples in the code descriptors. The examples do not represent all conditions in which testing of the gene may be indicated.</u></p> <p><u>Codes that describe tests to assess for the presence of gene variants (see definitions) use common gene variant names. Typically, all of the listed variants would be tested. However, these lists are not exclusive. If other variants are also tested in the analysis, they would be included in the procedure and not reported separately. Full gene sequencing should not be reported using codes that assess for the presence of gene variants unless specifically stated in the code descriptor. The molecular pathology codes include all analytical services performed in the test (eg, cell lysis, nucleic acid stabilization, extraction, digestion, amplification, and detection). Any procedures required prior to cell lysis (eg, microdissection, codes 88380 and 88381) should be reported separately.</u></p> <p><u>The molecular pathology codes include all analytical services performed in the test (eg, cell lysis, nucleic acid stabilization, extraction, digestion, amplification, and detection). Any procedures required prior to cell lysis (eg, microdissection, codes 88380 and 88381) should be reported separately.</u></p> <p><u>The results of the procedure may require interpretation by a. When only the interpretation and report are performed, modifier 26 may be appended to the specific molecular pathology code.</u></p> <p><u>All analyses are qualitative unless otherwise noted.</u></p> <p><u>For microbial identification, see 87149-87153 and 87470-87801, and 87900-87904. For in situ hybridization analyses, see 88271-88275 and 88365-88368.</u></p> <p><u>Molecular pathology procedures that are not specified in 81200-81350 should be reported using the appropriate methodology codes in the 83890-83914 and 88384-88386 series.</u></p>				

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●81200		ASPA (aspartoacylase) (eg, Canavan disease) gene analysis; common variants (eg, E285A, Y231X)	XXX	Not Typically Performed by Physicians at this Time
●81205		BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, Maple syrup urine disease) gene analysis; common variants (eg, R183P, G278S, E422X)	XXX	Not Typically Performed by Physicians at this Time
●81206	M1	BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	XXX	0.37
●81207	M2	minor breakpoint, qualitative or quantitative	XXX	0.15
●81208	M3	other breakpoint, qualitative or quantitative	XXX	0.46
●81209		BLM (Bloom syndrome, RecQ helicase-like) (eg, Bloom syndrome) gene analysis; (eg, 2281del6ins7)	XXX	Not Typically Performed by Physicians at this Time
●81210	Z1	BRAF (v-raf murine sarcoma viral oncogene homolog B1) (eg, colon cancer), gene analysis, V600E variant	XXX	RUC Review September 2011
●81211		BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)	XXX	Not Typically Performed by Physicians at this Time
●81212		185delAG, 5385insC, 6174delT variants	XXX	Not Typically Performed by Physicians at this Time

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●81213		uncommon duplication/deletion variants	XXX	Not Typically Performed by Physicians at this Time
●81214		BRCA1 (breast cancer 1) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb) (When performing BRCA1 full sequence analysis with BRCA2 full sequence analysis use 81211)	XXX	Not Typically Performed by Physicians at this Time
●81215		known familial variant	XXX	Not Typically Performed by Physicians at this Time
●81216		BRCA2 (breast cancer 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis (When performing BRCA2 full sequence analysis with BRCA1 full sequence analysis use 81211)	XXX	Not Typically Performed by Physicians at this Time
●81217		known familial variant	XXX	Not Typically Performed by Physicians at this Time
●81220	M4	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	XXX	0.15
●81221	M5	known familial variants	XXX	0.40
●81222	M6	duplication/deletion variants	XXX	0.22
●81223	M7	full gene sequence	XXX	0.40

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●81224	M8	intron 8 poly-T analysis (eg, male infertility)	XXX	0.15
●81225	Z2	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	XXX	RUC Review September 2011
●81226	Z3	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)	XXX	RUC Review September 2011
●81227	Z4	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	XXX	RUC Review September 2011
●81228		Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)	XXX	Not Typically Performed by Physicians at this Time
●81229		interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities (Do not report 81228 in conjunction with 81229)	XXX	Not Typically Performed by Physicians at this Time
●81240	M9	F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant	XXX	0.13
●81241	M10	F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis; Leiden variant	XXX	0.13
●81242		FANCC (Fanconi anemia, complementation group C) (eg, Fanconi anemia, type C) gene analysis; common variant (eg, IVS4+4A>T)	XXX	Not Typically Performed by Physicians at this Time

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●81243	M11	FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles (For evaluation to detect and characterize abnormal alleles, see 81243, 81244) (For evaluation to detect and characterize abnormal alleles using a single assay [eg, PCR], use 81243)	XXX	0.37
●81244	M12	characterization of alleles (eg, expanded size and methylation status)	XXX	0.51
●81245	Z6	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)	XXX	RUC Review September 2011
●81250		G6PC (glucose-6-phosphatase, catalytic subunit) (eg, Glycogen storage disease, Type 1a, von Gierke disease) gene analysis; common variants (eg, R83C, Q347X)	XXX	Not Typically Performed by Physicians at this Time
●81251		GBA (glucosidase, beta, acid) (eg, Gaucher disease) gene analysis; common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)	XXX	Not Typically Performed by Physicians at this Time
●81255		HEXA (hexosaminidase A (alpha polypeptide) (eg, Tay-Sachs disease) gene analysis; common variants (eg, 1278insTATC, 1421+1G>C, G269S)	XXX	Not Typically Performed by Physicians at this Time
●81256	M13	HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)	XXX	0.13
●81257	Z7	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean,	XXX	RUC Review September 2011

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		alpha3.7, alpha4.2, alpha20.5, and Constant Spring)		
●81260		IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (eg, familial dysautonomia) gene analysis; common variants (eg, 2507+6T>C, R696P)	XXX	Not Typically Performed by Physicians at this Time
● 81261	Z8	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)	XXX	RUC Review September 2011
●81262	Z9	direct probe methodology (eg, Southern blot)	XXX	RUC Review September 2011
●81263	Z10	IGH@ (Immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis	XXX	RUC Review September 2011
●81264	Z11	IGK@ (Immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s) (For immunoglobulin lambda gene [IGL@] rearrangement or immunoglobulin kappa deleting element, [IGKDEL] analysis, report the appropriate methodology code[s] in the 83890-83914 series)	XXX	RUC Review September 2011
●81265	Z12	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	XXX	RUC Review September 2011

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
✚●81266	Z13	each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure) (Use 81266 in conjunction with 81265)	ZZZ	RUC Review September 2011
●81267	Z14	Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; without cell selection	XXX	RUC Review September 2011
●81268	Z15	with cell selection (eg, CD3, CD33), each cell type (If baseline STR analysis of recipient [using buccal swab or other germline tissue sample] and donor are performed after hematopoietic stem cell transplantation, report 81265-81266 in conjunction with 81267-81268 for chimerism testing)	XXX	RUC Review September 2011
●81270	M14	JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis; V617F variant	XXX	0.15
●81275	M15	KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis; variants in codons 12 and 13	XXX	0.50
●81280		Long QT syndrome gene analyses (eg, KCNQ1, KCNH2, SCN5A, KCNE1, KCNE2, KCNJ2, CACNA1C, CAV3, SCN4B, AKAP, SNTA1, and ANK2); full sequence analysis	XXX	Not Typically Performed by Physicians at this Time
●81281		known familial sequence variant	XXX	Not Typically Performed by Physicians at this Time

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●81282		duplication/deletion variants	XXX	Not Typically Performed by Physicians at this Time
●81290		MCOLN1 (mucolipin 1) (eg, Mucopolipidosis, type IV) gene analysis; common variants (eg, IVS3-2A>G, del6.4kb)	XXX	Not Typically Performed by Physicians at this Time
●81291	M16	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)	XXX	0.15
●81292	Z16	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	RUC Review September 2011
●81293	Z17	known familial variants	XXX	RUC Review September 2011
●81294	Z18	duplication/deletion variants	XXX	RUC Review September 2011
●81295	Z19	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	RUC Review September 2011
●81296	Z20	known familial variants	XXX	RUC Review September 2011
●81297	Z21	duplication/deletion variants	XXX	RUC Review September 2011
●81298	Z22	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	RUC Review September 2011
●81299	Z23	known familial variants	XXX	RUC Review September 2011

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●81300	Z24	duplication/deletion variants	XXX	RUC Review September 2011
●81301	Z25	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed	XXX	RUC Review September 2011
●81302	Z26	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis	XXX	RUC Review September 2011
● 81303	Z27	known familial variant	XXX	RUC Review September 2011
●81304	Z28	duplication/deletion variants	XXX	RUC Review September 2011
●81310	Z29	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, exon 12 variants	XXX	RUC Review September 2011
●81315	M17	PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	XXX	0.37
●81316	M18	single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative (For intron 3 and intron 6 [including exon 6 if performed] analysis, use 81315) (If both intron 6 and exon 6 are analyzed, without intron 3, use one unit of 81316)	XXX	0.22

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●81317	Z30	PMS2 (postmeiotic segregation increased 2 [<i>S. cerevisiae</i>]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis	XXX	RUC Review September 2011
●81318	Z31	known familial variants	XXX	RUC Review September 2011
●81319	Z32	duplication/deletion variants	XXX	RUC Review September 2011
●81330		SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis; common variants (eg, R496L, L302P, fsP330)	XXX	Not Typically Performed by Physicians at this Time
●81331	Z33	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis	XXX	RUC Review September 2011
●81332	Z34	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)	XXX	RUC Review September 2011
●81340	Z35	TCB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	XXX	RUC Review September 2011
●81341	Z36	using direct probe methodology (eg, Southern blot)	XXX	RUC Review September 2011
●81342	Z37	TCG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	XXX	RUC Review September 2011

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		(For T cell antigen alpha [TCA@] gene rearrangement analysis, report the appropriate methodology code(s) in the 83890-83914 series) (For T cell antigen delta [TCD@] gene rearrangement analysis, report 81341)		
●81350	Z38	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)	XXX	RUC Review September 2011
●81355	Z5	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)	XXX	RUC Review September 2011
<p><u>Human Leukocyte Antigen (HLA) typing is performed to assess compatibility of recipients and potential donors as a part of solid organ and hematopoietic stem cell pretransplant testing. HLA testing is also performed to identify HLA alleles and allele groups (antigen equivalents) associated with specific diseases and individualized responses to drug therapy (eg, HLA-B*27 and ankylosing spondylitis and HLA-B*57:01 and abacavir hypersensitivity) as well as other clinical uses. One or more HLA genes may be tested in specific clinical situations (eg, HLA-DQB1 for narcolepsy and HLA-A, -B, -C, -DRB1 and -DQB1 for kidney transplantation). Each HLA gene typically has multiple variant alleles or allele groups that can be identified by typing. For HLA result reporting, a low resolution HLA type is denoted by a two digit HLA name (eg, A*02) and high resolution typing is denoted by a greater number of digits (eg, A*02:02, *03:01:01:01, and C*03:04P). If additional testing is required to resolve ambiguous allele combinations for high resolution typing, it is included in the HLA typing code. The gene names have been italicized similar to the other molecular pathology codes.</u></p> <p><u>(For HLA antigen typing by non-molecular pathology techniques, see 86812-86822)</u></p>				
●81370	Z39	HLA Class I and II typing, low resolution (eg, antigen equivalents); HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1	XXX	RUC Review September 2011
●81371	Z40	HLA-A, -B, and -DRB1/3/4/5 (eg, verification typing)	XXX	RUC Review September 2011

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●81372	Z41	HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, HLA-A, -B, and -C) (When performing both Class I and II low resolution HLA typing for HLA-A,-B,-C, -DRB1/3/4/5, and -DQB1, use 81370)	XXX	RUC Review September 2011
●81373	Z42	one locus (eg, HLA-A, -B, or -C), each (When performing a complete Class I [HLA-A,-B, and -C] low resolution HLA typing, use 81372) (When the presence or absence of a single antigen equivalent is reported using low resolution testing, use 81374)	XXX	RUC Review September 2011
●81374	Z43	one antigen equivalent (eg, B*27), each (When testing for presence or absence of more than 2 antigen equivalents at a locus, use HLXX4 for each locus tested)	XXX	RUC Review September 2011
●81375	Z44	HLA Class II typing, low resolution (eg, antigen equivalents); HLA-DRB1/3/4/5 and -DQB1 (When performing both Class I and II low resolution HLA typing for HLA-A,-B,-C, -DRB1/3/4/5, and -DQB1, use 81370)	XXX	RUC Review September 2011
●81376	Z45	one locus (eg, HLA-DRB1/3/4/5, -DQB1, -DQA1, -DPB1, or -DPA1), each (When low resolution typing is performed for HLA-DRB1/3/4/5 and -DQB1, use HLXX6) (For low resolution typing, HLA-DRB1/3/4/5 should be	XXX	RUC Review September 2011

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		treated as a single locus)		
●81377	Z46	one antigen equivalent, each (When testing for presence or absence of more than 2 antigen equivalents at a locus, use 81379 for each locus)	XXX	RUC Review September 2011
●81378	Z47	HLA Class I and II typing, high resolution (ie, alleles or allele groups), HLA-A, -B, -C, and -DRB1	XXX	RUC Review September 2011
●81379	Z48	HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, HLA-A, -B, and -C)	XXX	RUC Review September 2011
●81380	Z49	one locus (eg, HLA-A, -B, or -C), each (When a complete Class I high resolution typing for HLA-A, -B, and -C is performed, use 81379) (When the presence or absence of a single allele or allele group is reported using high resolution testing, use 81381)	XXX	RUC Review September 2011
●81381	Z50	one allele or allele group (eg, B*57:01P), each (When testing for the presence or absence of more than 2 alleles or allele groups at a locus, use 81380 for each locus)	XXX	RUC Review September 2011
●81382	Z51	HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, HLA-DRB1, -DRB3, -DRB4, -DRB5, -DQB1, -DQA1, -DPB1, or -DPA1), each (When only the presence or absence of a single allele or allele group is reported using high resolution testing, use 81383)	XXX	RUC Review September 2011
●81383	Z52	one allele or allele group (eg, HLA-DQB1*06:02P),	XXX	RUC Review September 2011

CPT Code (●New)	Tracking Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		each (When testing for the presence or absence of more than 2 alleles or allele groups at a locus, use 81382 for each locus)		
83912		Molecular diagnostics; interpretation and report	XXX	0.37 (No Change)
E 86822		HLA typing; lymphocyte culture, primed (PLC) (For HLA typing by molecular pathology techniques, see 81370-8138383890-83914 with appropriate genetic testing modifiers 4A-4G)	XXX	Paid on Clinical Lab Fee Schedule



February 25, 2011

Barbara Levy, MD
Chair, RVS Update Committee
American Medical Association
515 N. State St.
Chicago, IL 60654

Re: New Molecular Pathology CPT Codes

Dear Dr. Levy:

The College of American Pathologists (CAP) supports physician fee schedule placement of the 28 Tier 1 molecular pathology codes approved at the October 2010 CPT Meeting, and the 9 Tier 2 codes approved at the February 2011 CPT meeting, as they all have a professional interpretive component. However, the Centers for Medicare and Medicaid Services (CMS) and the AMA/Specialty Society Relative Value Scale Update Committee (RUC) have specifically requested that the CAP bring forward at this time only proposed values for April 2011 RUC review that typically include physician interpretation.

The 28 Tier 1 codes and 9 Tier 2 codes identified in CAP's plan for review at the April RUC have been reviewed by a subgroup of CAP molecular pathologists together with our RBRVS workgroup. Of these 37 codes, 10 were determined to have their interpretation typically performed by a PhD at this time. These services are currently not typically performed in typical molecular pathology laboratories, but rather in subspecialty laboratories.

Therefore, in response to CMS' and the RUC's direct request, only the following codes will be presented at the April RUC meeting, because the interpretation of these codes is typically performed by a physician. In addition, the CAP reviewed the recently approved CPT codes from the February CPT meeting and determined which codes are typically interpreted by physicians.

As you know, at the February meeting, the RUC approved a plan outlining how CAP proposes to move forward in developing recommended values and direct practice expense inputs for the molecular pathology codes approved by the CPT Editorial Panel at its October 2010 and February 2011 meetings. This plan is to survey for April 2011 the 28 Tier 1 molecular codes and the 9 Tier 2 codes approved by CPT in February. Because of the RUC directive, 27 codes will be surveyed for the April RUC meeting. The remaining molecular codes approved at the February CPT meeting and identified as typically including physician work will be surveyed for the September 2011 RUC meeting.

Below please find the codes to be surveyed for the April 2011 RUC meeting, codes to be surveyed for the September 2011 RUC meeting, and codes not scheduled to be surveyed at this time.

College of American Pathologists

Codes to be Surveyed for April 2011 RUC Meeting

Tier 1

- BXXX2 *BCR/ABL1 (t[9;22])* (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative
- BXXX3 minor breakpoint, qualitative or quantitative
- BXXX4 other breakpoint, qualitative or quantitative
- CXXX1 *CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)
- CXXX2 known familial variants
- CXXX3 duplication/deletion variants
- CXXX4 full gene sequence
- CXXX5 intron 8 poly-T analysis (eg, male infertility)
- FXXX1 *F2 (prothrombin, coagulation factor II)* (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant
- FXXX2 *F5 (coagulation Factor V)* (eg, hereditary hypercoagulability) gene analysis; Leiden variant
- FXXX4 *FMR1 (Fragile X mental retardation 1)* (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
- FXXX5 characterization of alleles (eg, expanded size and methylation status)
- HXXX2 *HFE (hemochromatosis)* (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)
- JXXX1 *JAK2 (Janus kinase 2)* (eg, myeloproliferative disorder) gene analysis; V617F variant
- KXXX1 *KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene)* (eg, carcinoma) gene analysis; variants in codons 12 and 13
- MXXX2 *MTHFR (5,10-methylenetetrahydrofolate reductase)* (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)
- PXXX1 *PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1)* (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative
- PXXX2 single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative

Tier 2

- L2XX1 Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)
- L2XX2 Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)

College of American Pathologists

- L2XX3 Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)
- L2XX4 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)
- L2XX5 Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)
- L2XX6 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)
- L2XX7 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)
- L2XX8 Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)
- L2XX9 Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)

Codes to be Surveyed for September 2011 RUC Meeting

Tier 1

- BXXX6 *BRAF (v-raf murine sarcoma viral oncogene homolog B1)* (eg, colon cancer), gene analysis, V600E variant
- CXXX6 *CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)
- CXXX7 *CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)
- CXXX8 *CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)
- CXXX9 *VKORC1 (vitamin K epoxide reductase complex, subunit 1)* (eg, warfarin metabolism), gene analysis, common variants (eg, 1639/3673)
- FXXX6 *FLT3 (fms-related tyrosine kinase 3)* (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)
- HXXX3 *HBA1/HBA2 (alpha globin 1 and alpha globin 2)* (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)

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- IXXX2 *IGH@ (Immunoglobulin heavy chain locus)* (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)
- IXXX3 direct probe methodology (eg, Southern blot)
- IXXX4 *IGH@ (Immunoglobulin heavy chain locus)* (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis
- IXXX5 *IGK@ (Immunoglobulin kappa light chain locus)* (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
- IXXX6 Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)
- +● IXXX7 each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)
- IXXX8 Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; without cell selection
- IXXX9 with cell selection (eg, CD3, CD33), each cell type
- MXXX3 *MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2)* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
- MXXX4 known familial variants
- MXXX5 duplication/deletion variants
- MXXX6 *MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1)* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
- MXXX7 known familial variants
- MXXX8 duplication/deletion variants
- MXXX9 *MSH6 (mutS homolog 6 [E. coli])* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
- MXX10 known familial variants
- MXX11 duplication/deletion variants

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- MXX12 Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed
- MXX13 *MECP2 (methyl CpG binding protein 2)* (eg, Rett syndrome) gene analysis; full sequence analysis
- MXX14 known familial variant
- MXX15 duplication/deletion variants
- NXXX3 *NPM1 (nucleophosmin)* (eg, acute myeloid leukemia) gene analysis, exon 12 variants
- PXXX3 *PMS2 (postmeiotic segregation increased 2 [S. cerevisiae])* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
- PXXX4 known familial variants
- PXXX5 duplication/deletion variants
- SXXX2 *SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A)* (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis
- SXXX3 *SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1)* (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)
- TXXX1 *TCB@ (T cell antigen receptor, beta)* (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)
- TXXX2 using direct probe methodology (eg, Southern blot)
- TXXX3 *TCG@ (T cell antigen receptor, gamma)* (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
- UXXX1 *UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1)* (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)
- HLXX1 HLA Class I and II typing, low resolution (eg, antigen equivalents); *HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1*
- HLXX2 *HLA-A, -B, and -DRB1/3/4/5* (eg, verification typing)
- HLXX3 HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, *HLA-A, -B, and -C*)
- HLXX4 one locus (eg, *HLA-A, -B, or -C*), each
- HLXX5 one antigen equivalent (eg, *B*27*), each
- HLXX6 HLA Class II typing, low resolution (eg, antigen equivalents); *HLA-DRB1/3/4/5 and -DQB1*

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- HLXX7 one locus (eg, *HLA-DRB1/3/4/5*, *-DQB1*, *-DQA1*, *-DPB1*, or *-DPA1*), each
- HLXX8 one antigen equivalent, each
- HLXX9 HLA Class I and II typing, high resolution (ie, alleles or allele groups), *HLA-A*, *-B*, *-C*, and *-DRB1*
- HLX10 HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, *HLA-A*, *-B*, and *-C*)
- HLX11 one locus (eg, *HLA-A*, *-B*, or *-C*), each
- HLX12 one allele or allele group (eg, *B*57:01P*), each
- HLX13 HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, *HLA-DRB1*, *-DRB3*, *-DRB4*, *-DRB5*, *-DQB1*, *-DQA1*, *-DPB1*, or *-DPA1*), each
- HLX14 one allele or allele group (eg, *HLA-DQB1*06:02P*), each

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Codes not being surveyed at this time per RUC/CMS directive to CAP

(October 2010 CPT Meeting)

- Axxx1 ASPA (*aspartoacylase*) (eg, Canavan disease) gene analysis; common variants (eg, E285A, Y231X)
- Bxxx1 BCKDHB (*branched-chain keto acid dehydrogenase E1, beta polypeptide*) (eg, Maple syrup urine disease) gene analysis; common variants (eg, R183P, G278S, E422X)
- Bxxx5 BLM (*Bloom syndrome, RecQ helicase-like*) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant
- Fxxx3 FANCC (*Fanconi anemia, complementation group C*) (eg, Fanconi anemia, type C) gene analysis; common variant (eg, IVS4+4A>T)
- Gxxx1 G6PC (*glucose-6-phosphatase, catalytic subunit*) (eg, Glycogen storage disease, Type 1a, von Gierke disease) gene analysis; common variants (eg, R83C, Q347X)
- Gxxx2 GBA (*glucosidase, beta, acid*) (eg, Gaucher disease) gene analysis; common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)
- Hxxx1 HEXA (*hexosaminidase A (alpha polypeptide)*) (eg, Tay-Sachs disease) gene analysis; common variants (eg, 1278insTATC, 1421+1G>C, G269S)
- Ixxx1 IKBKAP (*inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein*) (eg, familial dysautonomia) gene analysis; common variants (eg, 2507+6T>C, R696P)
- Mxxx1 MCOLN1 (*muco lipin 1*) (eg, Mucopolipidosis, type IV) gene analysis; common variants (eg, IVS3-2A>G, del6.4kb)
- Sxxx1 SMPD1 (*sphingomyelin phosphodiesterase 1, acid lysosomal*) (eg, Niemann-Pick disease, Type A) gene analysis; common variants (eg, R496L, L302P, fsP330)

(February 2011 CPT Meeting)

- Bxxx7 BRCA1, BRCA2 (*breast cancer 1 and 2*) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)
- Bxxx8 185delAG, 5385insC, 6174delT variants
- Bxxx9 uncommon duplication/deletion variants
- Bxx10 BRCA1 (*breast cancer 1*) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)
- Bxxx11 known familial variant
- Bxx12 BRCA2 (*breast cancer 2*) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis

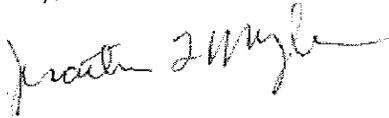
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- BXX13 known familial variant
- CXX10 Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)
- CXX11 interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities
- LXXX1 Long QT syndrome gene analyses (eg, *KCNQ1*, *KCNH2*, *SCN5A*, *KCNE1*, *KCNE2*, *KCNJ2*, *CACNA1C*, *CAV3*, *SCN4B*, *AKAP*, *SNTA1*, and *ANK2*); full sequence analysis
- LXXX2 known familial sequence variant
- LXXX3 duplication/deletion variants

If you have any questions or concerns, please contact Kim Chisolm, Assistant Director of Economic Affairs at (202) 354-7118 or kchisol@cap.org.

Thank you for providing us the opportunity to present this plan.

Sincerely,



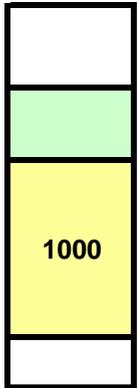
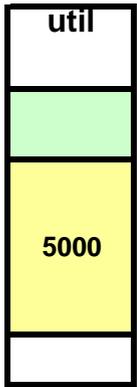
Jonathan L. Myles, MD, FCAP
CAP RUC Advisor
College of American Pathologists

jlm/kmc
Sent via email

cc: Kenneth Simon, MD, MBA, CMS
Edith Hambrick, MD, JD, CMS
Susan Spires, MD, RUC Member
J. Allan Tucker, MD, RUC Alternate Member
Mark Synovec, MD, CPT Member
Sherry Smith, AMA RUC Staff
Roseanne Fischhoff, AMA RUC Staff
Kim Chisolm, CAP RUC Staff
Ayanna Wooding, CAP CPT Staff

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	Total-TIME				
					MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
REF	86320	Immunoelectrophoresis; serum	32	0.0220			0.37			17			17		
SVY	81315	PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	27	0.035	0.20	0.51	0.52	0.61	0.95		3	8	15	23	30
REC				0.025			0.37						15		

Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	Total-TIME				
					MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX
REF	88304	Level III - Surgical pathology, gross and microscopic examination					0.22			15			15		
SVY	81316	PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	15	0.038	0.20	0.37	0.45	0.57	0.80		5	8	12	18	30
REC				0.018			0.22						12		



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

CPT Code: 81206 Tracking Number M1 Original Specialty Recommended RVU: **0.39**
Presented Recommended RVU: **0.37**
Global Period: XXX RUC Recommended RVU: **0.37**

CPT Descriptor: BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old man diagnosed with chronic myelogenous leukemia (CML) on maintenance therapy with imatinib mesylate sees his oncologist for a routine follow-up visit. Molecular studies at diagnosis confirmed the presence of a Philadelphia chromosome with the major breakpoint translocation joining the BCR and ABL1 genes. The patient feels well and has no complaints, and a hemogram in the office demonstrates normal white cell, red cell, and platelet counts. A sample of anticoagulated peripheral blood is submitted to the laboratory for quantitative assessment of BCR/ABL1 major breakpoint transcript level.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality total cellular RNA is isolated and stored under RNase-free conditions. Working in duplicate from this point, reverse transcriptase is used to convert RNA to cDNA followed by quantitative real-time PCR amplification using primers for both the BCR/ABL1 major breakpoint translocation as well as a 'housekeeping gene' necessary to normalize BCR/ABL1 expression levels. The physician reviews the real-time PCR tracings to determine the status of the of BCR/ABL1 major breakpoint transcripts, that the assay is performing at acceptable sensitivity, and whether RNA degradation or inhibitors of PCR are present. The physician reviews duplicate values as well as the ratio of BCR/ABL1 to housekeeping gene expression for patient and control samples. Values are converted to an international reporting standard using a previously-determined correction factor for the laboratory's assay. The physician composes a report that describes the transcript status and copy number, and compares these results with the patient's previous results. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81206				
Sample Size:	450	Resp N:	62	Response: 13.7 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		20.00	50.00	100.00	200.00
Survey RVW:		0.10	0.41	0.52	0.74
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	10.00	15.00	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 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
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:	81206	Recommended Physician Work RVU: 0.37		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		15.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.31	RUC Time	1,231,072

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 26 % of respondents: 41.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81206	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
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	15.00	20.00	

Other time if appropriate		
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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	3.23	3.69
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.54
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Urgency of medical decision making	3.62	3.54
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.92	4.15
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Physical effort required	3.00	3.12
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.62	3.69
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Outcome depends on the skill and judgment of physician	3.62	3.69
--	------	------

Estimated risk of malpractice suit with poor outcome	3.08	3.19
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	3.69	3.86
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Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.39.

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) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

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 College of American Pathologists

How often? Sometimes

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	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
35,000 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? 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

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. 83912-26

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

CPT Code: 81207 Tracking Number M2 Original Specialty Recommended RVU: **0.29**
Presented Recommended RVU: **0.15**
Global Period: XXX RUC Recommended RVU: **0.15**

CPT Descriptor: BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 64-year-old-woman diagnosed with acute lymphocytic leukemia (ALL) treated with imatinib mesylate and hyper-CVAD therapy sees her oncologist for a routine follow-up visit. Molecular studies at diagnosis confirmed the presence of a Philadelphia chromosome with the minor breakpoint translocation joining the BCR and ABL1 genes. The patient feels well and has no complaints, and a hemogram in the office demonstrates normal white cell, red cell, and platelet counts. A sample of anticoagulated bone marrow is submitted to the laboratory for quantitative assessment of BCR/ABL1 minor breakpoint transcript level.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality total cellular RNA is isolated and stored under RNase-free conditions. Working in duplicate from this point, reverse transcriptase is used to convert RNA to cDNA followed by quantitative real-time PCR amplification using primers for both the BCR/ABL1 minor breakpoint translocation as well as a 'housekeeping gene' necessary to normalize BCR/ABL1 expression levels. The physician reviews the real-time PCR tracings to determine the status of BCR/ABL1 minor breakpoint transcripts, that the assay is performing at acceptable sensitivity and whether RNA degradation or inhibitors of PCR are present. The physician reviews duplicate values as well as the ratio of BCR/ABL1 to housekeeping gene expression for patient and control samples. The physician composes a report that describes the transcript status and whether disease level appears to be stable, increasing or decreasing. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81207				
Sample Size:	450	Resp N:	30	Response: 6.6 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	20.00	50.00	100.00
Survey RVW:		0.25	0.40	0.50	0.55
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	10.00	11.00	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 0.00	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:	81207	Recommended Physician Work RVU: 0.15		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		11.00		
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 17 % of respondents: 56.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81207	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	11.00	20.00	
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	11.00	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	3.29	3.76
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.76	3.47
--	------	------

Urgency of medical decision making	3.53	3.29
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	4.00
--------------------------	------	------

Physical effort required	2.94	2.88
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.65	3.47
---	------	------

Outcome depends on the skill and judgment of physician	3.76	3.76
--	------	------

Estimated risk of malpractice suit with poor outcome	2.88	3.06
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.65	3.88
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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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.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 83912-26

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

CPT Code:81208 Tracking Number M3 Original Specialty Recommended RVU: **0.46**
Presented Recommended RVU: **0.46**
Global Period: XXX RUC Recommended RVU: **0.46**

CPT Descriptor: BCR/ABL1 (t[9;22]) (eg, chronic myelogenous leukemia) translocation analysis ;other breakpoint, qualitative or quantitative

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old woman visits her primary care physician complaining of abdominal discomfort. Splenomegaly is identified on physical examination. A hemogram demonstrates leukocytosis with a left shift along with modest anemia and thrombocytopenia. Cytogenetic analysis demonstrates a classic Philadelphia chromosome, but studies for BCR/ABL1 major and minor breakpoints are negative. A sample of anticoagulated peripheral blood is submitted to the laboratory for assessment of the uncommon BCR/ABL1 ‘micro’(u) translocation breakpoint.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality total cellular RNA is isolated and stored under RNase-free conditions. Working in duplicate from this point, reverse transcriptase is used to convert RNA to cDNA followed by qualitative real-time PCR amplification using primers specific for the BCR/ABL1 micro(u) breakpoint translocation as well as a ‘housekeeping gene. The physician reviews the real-time PCR tracings to the status of a BCR/ABL1 micro breakpoint translocation and whether RNA degradation or inhibitors of PCR are present. The physician composes a report which specifies the status of the translocation. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81208				
Sample Size:	450	Resp N:	16	Response: 3.5 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	10.00	25.00	52.50
Survey RVW:		0.45	0.46	0.50	0.52
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	15.00	18.00	30.00
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
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:	81208	Recommended Physician Work RVU: 0.46		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		18.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92250	XXX	0.44	RUC Time	2,175,839

CPT Descriptor 1 Fundus photography with interpretation and report

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92083	XXX	0.50	RUC Time	2,580,775

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 11 % of respondents: 68.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81208	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	18.00	20.00	
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	18.00	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	3.82	3.64
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.82	3.55
--	------	------

Urgency of medical decision making	3.64	3.64
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.91	3.91
--------------------------	------	------

Physical effort required	3.00	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.45	3.36
---	------	------

Outcome depends on the skill and judgment of physician	3.82	3.82
--	------	------

Estimated risk of malpractice suit with poor outcome	3.64	3.64
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.73	3.55
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

Specialty	Frequency	Percentage	%
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

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. 83912-26

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

CPT Code:81220 Tracking Number M4 Original Specialty Recommended RVU: **0.22**
Presented Recommended RVU: **0.15**
Global Period: XXX RUC Recommended RVU: **0.15**

CPT Descriptor: CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 26-year-old Caucasian woman, approximately 8 weeks pregnant and otherwise in good health, visits her obstetrician for a first prenatal visit. After discussing advantages and limitations of prenatal cystic fibrosis carrier screening with her obstetrician, an anticoagulated peripheral blood sample is sent to the laboratory to be tested for common mutations and variants associated with cystic fibrosis.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated and subjected to multiplex PCR. Following exonuclease I and shrimp alkaline phosphatase treatment, a second reaction using allele specific primer extension (ASPE) amplifies either the normal or mutant allele sequences. Extension products are hybridized to color-coded microspherical beads specific for normal and mutant alleles. The fluorescent signal ratio of mutant to normal alleles is calculated, and the physician examines the allelic ratios to determine the mutation and zygosity status. The physician composes a report which specifies the patient's mutation status and residual risk based on ethnic background. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81220				
Sample Size:	450	Resp N:	32	Response:	7.1 %
Sample Type:	Convenience Additional Sample Information:				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	10.00	250.00	425.00	800.00
Survey RVW:	0.15	0.38	0.50	0.66	1.30
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	4.00	8.00	10.00	20.00	40.00
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: XXX Global Code

CPT Code:	81220	Recommended Physician Work RVU: 0.15		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
86320	XXX	0.37	RUC Time

CPT Descriptor Immuno-electrophoresis; serum**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93010	XXX	0.17	RUC Time	19,334,268

CPT Descriptor 1 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 12 % of respondents: 37.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81220	<u>Key Reference CPT Code:</u> 86320	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	10.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
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	17.00	
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	2.75	3.08
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.75	2.83
--	------	------

Urgency of medical decision making	3.08	2.95
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.25	3.00
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Physical effort required	2.08	2.17
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.42	3.00
---	------	------

Outcome depends on the skill and judgment of physician	3.25	3.17
--	------	------

Estimated risk of malpractice suit with poor outcome	4.33	3.50
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	3.08	3.00
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Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWP/UT for 86320. This number

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 83912-26

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

CPT Code:81221 Tracking Number M5

Original Specialty Recommended RVU: **0.40**Presented Recommended RVU: **0.40**

Global Period: XXX

RUC Recommended RVU: **0.40**

CPT Descriptor: CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 1-year-old Caucasian boy whose 6-year-old brother was previously diagnosed with cystic fibrosis is brought by his mother to the pediatrician for genetic testing. The brother was previously demonstrated to be a compound heterozygote carrying one copy each of the common CFTR DeltaF508 mutation as well as a rare variant not included in assays which test for common variants of CFTR but known to cause cystic fibrosis. An anticoagulated peripheral blood sample is sent to the laboratory for testing of these known mutations.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality DNA is isolated from whole blood and subjected to PCR amplification for the respective CFTR gene exons which contain the known familial mutations. Following exonuclease I and shrimp alkaline phosphatase treatment, each PCR product undergoes bidirectional Sanger dideoxynucleotide chain termination sequencing using appropriate forward and reverse primers. Sequencing products are analyzed on a capillary electrophoresis instrument and electropherograms printed for visual inspection and transferred to a software program to identify potential nucleotide sequence changes. The physician composes a report specifying the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81221				
Sample Size:	450	Resp N:	13	Response:	2.8 %
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	12.00	20.00	50.00
Survey RVW:		0.32	0.40	0.50	0.77
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		6.00	10.00	20.00	25.00
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
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:	81221	Recommended Physician Work RVU: 0.40		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	090	0.22	RUC Time	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 6 % of respondents: 46.1 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81221	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
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	20.00	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	3.67	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.67	3.67
--	------	------

Urgency of medical decision making	3.83	4.00
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.17	4.17
--------------------------	------	------

Physical effort required	3.17	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.33	3.83
---	------	------

Outcome depends on the skill and judgment of physician	4.33	4.33
--	------	------

Estimated risk of malpractice suit with poor outcome	4.83	4.33
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.83	3.83
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWP/UT for 88291. This number

Specialty	Frequency	Percentage	%
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

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. 83912-26

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

CPT Code:81222 Tracking Number M6 Original Specialty Recommended RVU: **0.28**
Presented Recommended RVU: **0.22**
Global Period: XXX RUC Recommended RVU: **0.22**

CPT Descriptor: CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17-year-old Caucasian female previously diagnosed with cystic fibrosis based on convincing clinical criteria and two elevated sweat chloride results visits her pediatrician with her father to discuss potential additional genetic testing. Previous tests with a screening assay for common mutations and variants followed by CFTR full gene sequence analysis revealed only heterozygosity for the DeltaF508 mutation. An anticoagulated peripheral blood sample is forwarded to a reference laboratory for deletion/duplication analysis for an uncommon CFTR mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen high quality DNA is isolated from whole blood and subjected to multiplex ligation probe ligation analysis (MLPA) which involves hybridization and ligation of multiple pairs of oligonucleotide probes specific for the 27 exons of the CFTR gene to assess dosage of each exon. The physician examines peak heights and calculated ratios of individual exons to control gene sequences to determine dosage status for all exons tested in the CFTR gene. The physician composes a report specifying the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP					
Specialty(s):	College of American Pathologists					
CPT Code:	81222					
Sample Size:	450	Resp N:	6	Response: 1.3 %		
Sample Type:	Convenience	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		25.00	72.50	250.00	300.00	500.00
Survey RVW:		0.22	0.33	0.40	0.44	0.52
Pre-Service Evaluation Time:				0.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		5.00	10.00	13.00	19.00	25.00
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: XXX Global Code

CPT Code:	81222	Recommended Physician Work RVU: 0.22		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		13.00		
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
86320	XXX	0.37	RUC Time

CPT Descriptor Immuno-electrophoresis; serum**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 3 % of respondents: 50.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81222	<u>Key Reference CPT Code:</u> 86320	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	13.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
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	13.00	17.00	
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	4.00	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.67
--	------	------

Urgency of medical decision making	3.00	3.67
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	4.00
--------------------------	------	------

Physical effort required	2.33	2.33
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.67	4.00
---	------	------

Outcome depends on the skill and judgment of physician	4.00	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	4.67	4.67
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.67	3.33
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

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.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

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

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. 83912-26

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

CPT Code:81223 Tracking Number M7 Original Specialty Recommended RVU: **0.52**
Presented Recommended RVU: **0.40**
Global Period: XXX RUC Recommended RVU: **0.40**

CPT Descriptor: CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17-year-old Caucasian female with chronic rhino-sinusitis, idiopathic bronchiectasis and two sweat chloride measurements in the intermediate range (40-60 meq/L) is suspected by her pediatrician of having an atypical form of cystic fibrosis. A tube of anticoagulated peripheral blood is submitted to the laboratory for full CFTR gene sequence analysis.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality DNA is isolated from whole blood and subjected to 29 individual PCR amplification reactions whose products encompass the entire coding sequence, exon-intron boundaries and portions of 5' and 3'-untranslated regions of the CFTR gene. Following exonuclease I and shrimp alkaline phosphatase treatment, each PCR product undergoes bidirectional Sanger dideoxynucleotide chain termination sequencing using appropriate forward and reverse primers. Sequencing products are analyzed on a capillary electrophoresis instrument and electropherograms printed for visual inspection and transferred to a software program to identify potential nucleotide sequence changes. The physician composes a report specifying the patient's mutation status to include information from a literature and database search regarding the significance of variants identified. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81223				
Sample Size:	450	Resp N:	9	Response: 2.0 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	10.00	20.00	50.00
Survey RVW:		0.52	0.52	0.75	0.77
Pre-Service Evaluation Time:				0.00	
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
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
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:	81223	Recommended Physician Work RVU: 0.40		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92083	XXX	0.50	RUC Time	2,580,775

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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11000	000	0.60	RUC Time	115,072

CPT Descriptor 2 Debridement of extensive eczematous or infected skin; up to 10% of body surface

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 5 % of respondents: 55.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81223	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
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	20.00	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	4.20	4.20
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.20	4.20
--	------	------

Urgency of medical decision making	4.20	4.20
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.20	4.20
--------------------------	------	------

Physical effort required	3.20	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.40	4.40
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Outcome depends on the skill and judgment of physician	4.40	4.60
--	------	------

Estimated risk of malpractice suit with poor outcome	4.40	4.40
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.60	4.40
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.52.

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) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

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 College of American Pathologists How often? Sometimes

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	%
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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? 1,000
 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? 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

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. 83912-26

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

CPT Code:81224 Tracking Number M8 Original Specialty Recommended RVU: **0.22**
Presented Recommended RVU: **0.15**
Global Period: XXX RUC Recommended RVU: **0.15**

CPT Descriptor: CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Following recent consultation with his family physician regarding his wife's difficulty in conceiving a child, a 34-year-old Caucasian male is referred to an urologist for infertility workup. Further examination reveals bilateral absence of the vas deferens. The urologist recommends genetic analysis of the CFTR gene to look for common CFTR mutations and assess the intron 8 poly-T region frequently associated with male infertility. An anticoagulated peripheral blood sample is forwarded to the laboratory for testing.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated and subjected to multiplex PCR. Following exonuclease I and shrimp alkaline phosphatase treatment, a second reaction using allele specific primer extension (ASPE) amplifies either normal or mutant allele sequences including poly-T length variants. Extension products are hybridized to color-coded microspherical beads specific for normal and mutant alleles as well as poly-T length variants in intron 8. The fluorescent signal ratio of mutant, normal and poly-T alleles is calculated, and the physician examines the allelic ratios to determine the mutation, zygosity and specific poly-T allele status. The physician composes a report which specifies the patient's mutation and poly-T status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81224				
Sample Size:	450	Resp N:	14	Response: 3.1 %	
Sample Type:	Convenience Additional Sample Information:				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	3.00	6.25	20.00	55.75	500.00
Survey RVW:	0.32	0.40	0.49	0.79	0.94
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	3.00	8.00	10.00	15.00	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 0.00	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:	81224	Recommended Physician Work RVU: 0.15		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
86320	XXX	0.37	RUC Time

CPT Descriptor Immuno-electrophoresis; serum**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93010	XXX	0.17	RUC Time	19,334,268
<u>CPT Descriptor 1</u> Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 5 % of respondents: 35.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81224	<u>Key Reference CPT Code:</u> 86320	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	10.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
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	17.00	
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	2.80	2.60
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	2.80
--	------	------

Urgency of medical decision making	2.60	2.60
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	2.80	2.60
--------------------------	------	------

Physical effort required	2.20	2.40
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.60	2.60
---	------	------

Outcome depends on the skill and judgment of physician	2.80	2.80
--	------	------

Estimated risk of malpractice suit with poor outcome	3.40	3.00
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	2.80	2.60
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

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.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 83912-26

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

CPT Code:81240 Tracking Number M9 Original Specialty Recommended RVU: **0.15**
Presented Recommended RVU: **0.13**
Global Period: XXX RUC Recommended RVU: **0.13**

CPT Descriptor: F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old man with anxiety and kidney stones presented with two-week history of shortness of breath and pleuritic chest pain. Diagnostic workup revealed multiple bilateral pulmonary emboli. There was a vague history of other family members having “clotting problems.” A sample of anticoagulated peripheral blood is submitted to the laboratory for F2 (Prothrombin, coagulation factor II) mutation testing for the 20210G>A variant.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated. The genomic region containing the site of the F2 20210G>A mutation site is amplified by PCR and the amplicon is then subjected to melting curve analysis. The physician examines the melting curve plot of red fluorescent signal vs. temperature, as well as the plot of the negative first derivative of red fluorescent signal vs. temperature. Based on the analysis of these curves, and comparison to the results obtained with wild type and mutant controls, the physician determines the F2 20210G>A mutation and zygosity status. He or she composes a report which specifies the patient’s mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP					
Specialty(s):	College of American Pathologists					
CPT Code:	81240					
Sample Size:	450	Resp N:	42	Response:	9.3 %	
Sample Type:	Convenience	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		10.00	57.50	150.00	300.00	600.00
Survey RVW:		0.13	0.31	0.37	0.40	0.77
Pre-Service Evaluation Time:				0.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		2.00	5.00	7.00	10.00	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 0.00	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:	81240	Recommended Physician Work RVU: 0.13				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		7.00				
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
86320	XXX	0.37	RUC Time

CPT Descriptor Immuno-electrophoresis; serum**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95165	XXX	0.06	RUC Time	5,412,909
<u>CPT Descriptor 1</u> Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
73560	XXX	0.17	RUC Time	2,137,514

CPT Descriptor 2 Radiologic examination, knee; 1 or 2 views

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 50.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81240	<u>Key Reference CPT Code:</u> 86320	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	7.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
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	7.00	17.00	
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	2.52	2.95
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.57	3.00
--	------	------

Urgency of medical decision making	2.43	2.71
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.95	3.19
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Physical effort required	2.10	2.10
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.90	3.10
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Outcome depends on the skill and judgment of physician	2.81	3.24
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Estimated risk of malpractice suit with poor outcome	2.86	2.86
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	2.67	3.00
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Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWP/UT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.15.

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) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

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 College of American Pathologists

How often? Sometimes

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	%
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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?

22,000 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	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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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

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. 83912-26

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

CPT Code:81241 Tracking Number M10

Original Specialty Recommended RVU: **0.17**Presented Recommended RVU: **0.13**

Global Period: XXX

RUC Recommended RVU: **0.13**

CPT Descriptor: F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis; Leiden variant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old woman developed a right femoral venous thrombosis following a 3-hour airplane flight and subsequently developed pulmonary emboli. She had been on oral contraception. There was a vague history of other family members having "clotting problems." A functional, clot-based screening test for resistance to activated protein C (i.e., activated protein C resistance assay, APCR) was positive. A sample of anticoagulated peripheral blood is submitted to the laboratory for F5 Leiden mutation testing.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

 Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated. The genomic region containing the site of the F5 Leiden mutation site is amplified by PCR, and the amplicon is then subjected to melting curve analysis. The physician examines the melting curve plot of red fluorescent signal vs. temperature, as well as the plot of the negative first derivative of red fluorescent signal vs. temperature. Based on the analysis of these curves, and comparison to the results obtained with wild type and mutant controls, the physician determines the F5 Leiden mutation and zygosity status. He or she composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81241				
Sample Size:	450	Resp N:	41	Response: 9.1 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	50.00	150.00	300.00
Survey RVW:		0.13	0.30	0.37	0.40
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		2.00	5.00	8.00	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 0.00	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:	81241	Recommended Physician Work RVU: 0.13		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		8.00		
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
86320	XXX	0.37	RUC Time

CPT Descriptor Immunolectrophoresis; serum**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95165	XXX	0.06	RUC Time	5,412,909
<u>CPT Descriptor 1</u> Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 22 % of respondents: 53.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81241	<u>Key Reference CPT Code:</u> 86320	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	8.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
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	8.00	17.00	
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	2.59	2.95
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.64	2.91
--	------	------

Urgency of medical decision making	2.55	2.77
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.77	3.05
--------------------------	------	------

Physical effort required	2.05	2.14
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.86	3.00
---	------	------

Outcome depends on the skill and judgment of physician	2.86	3.09
--	------	------

Estimated risk of malpractice suit with poor outcome	2.95	2.95
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	2.59	2.86
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWP/UT for 86320. This number

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 83912-26

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

CPT Code:81243 Tracking Number M11

Original Specialty Recommended RVU: **0.37**Presented Recommended RVU: **0.37**

Global Period: XXX

RUC Recommended RVU: **0.37**

CPT Descriptor: FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 17-year-old man with moderate mental retardation (IQ 50 - 60) of above average height with a long narrow face, close set eyes, a highly arched palate, a prominent mandible, joint laxity in his fingers, and macroorchidism, presents to a physician for evaluation for the etiology of his mental retardation. Although his mother was of normal intelligence, his family history was remarkable for having an 18-year-old sister with a mild learning disability, a maternal aunt with premature ovarian failure, and a 68-year-old maternal grandfather with a progressive neurological illness characterized by development of a tremor, followed by difficulties with balance and occasional falling. A previously performed karyotype was normal. A sample of anticoagulated peripheral blood is submitted to the laboratory for FMR1 gene testing.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated. The genomic region containing the site of the CGG trinucleotide repeat region that is expanded in fragile X syndrome is amplified by using a PCR technique. The amplicon are then subjected to analysis using fluorescent capillary electrophoresis. The physician examines the electropherogram and compares it to a sizing ladder to determine the number of CGG repeats within the amplicon. Based on this analysis, the physician determines the patient's FMR1 allele status and whether additional characterization of alleles is necessary. He or she composes a report which specifies the patient's allele status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81243				
Sample Size:	450	Resp N:	13	Response:	2.8 %
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		20.00	50.00	120.00	300.00
Survey RVW:		0.20	0.37	0.50	0.55
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		3.00	8.00	15.00	15.00
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
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:	81243	Recommended Physician Work RVU: 0.37		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		15.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.31	RUC Time	1,231,072

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 8 % of respondents: 61.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81243	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
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	15.00	20.00	

Other time if appropriate		
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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	3.75	4.13
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	4.00
--	------	------

Urgency of medical decision making	2.88	3.75
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.25	4.38
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Physical effort required	2.88	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	4.00
---	------	------

Outcome depends on the skill and judgment of physician	3.88	4.13
--	------	------

Estimated risk of malpractice suit with poor outcome	3.63	4.00
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	3.75	4.00
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Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.37.

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) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

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 College of American Pathologists How often? Sometimes

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	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 900
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? 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

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. 83912-26

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

CPT Code:81244 Tracking Number M12

Original Specialty Recommended RVU: **0.51**Presented Recommended RVU: **0.51**

Global Period: XXX

RUC Recommended RVU: **0.51**

CPT Descriptor: FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a routine pediatric office visit, the mother of a 10-year-old girl describes what she considers to be unusual shyness leading to apparent social isolation, as well as occasional stereotypic behaviors such as hand wringing. The child attends regular school classes and her performance is somewhat below average. There is no family history of mental retardation or other neurologic problems. Both parents are healthy and of average intelligence and the patient has a 13-year-old brother who is otherwise healthy and performs well in school. The patient had a normal karyotype and array CGH study. FMR1 gene testing performed by gel-based PCR analysis revealed a single allele of normal CGG repeat size, but did not definitely show the presence of a second allele. A sample of anticoagulated peripheral blood is sent to the laboratory for Southern blot testing for fragile X syndrome utilizing a methylation specific enzyme.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, a large quantity of high quality genomic DNA is isolated. Gel electrophoresis of the extracted DNA is performed to assess DNA integrity. The DNA specimen undergoes double restriction digestion with the methylation-sensitive restriction enzyme EagI and the methylation-insensitive restriction enzyme EcoRI. The genomic fragments are separated by gel electrophoresis, transferred to a nylon membrane by capillary action, and hybridized to a labeled probe. The hybridization pattern is visualized on x-ray film by autoradiography. The physician examines the image, compares the observed fragments to a sizing ladder to estimate CGG repeat numbers, and analyzes the patterns generated to assess the methylation status of the promoter region of the expanded FMR1 allele. Based on this analysis the physician determines the patient's allele status, presence of expanded allele(s) and methylation status of the FMR1 promoter. He or she composes a report which specifies the patient's allele status, approximate allele sizes and promoter methylation status. The report is edited, signed and the results are communicated to the appropriate caregivers

Description of Post-Service Work: n/a

CPT Code: 81244

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81244				
Sample Size:	450	Resp N:	11	Response: 2.4 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		20.00	32.50	50.00	185.00
Survey RVW:		0.37	0.51	0.55	0.63
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	12.00	20.00	22.00
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
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:	81244	Recommended Physician Work RVU: 0.51		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92250	XXX	0.44	RUC Time	2,175,839

CPT Descriptor 1 Fundus photography with interpretation and report

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11000	000	0.60	RUC Time	115,072

CPT Descriptor 2 Debridement of extensive eczematous or infected skin; up to 10% of body surfacee

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 6 % of respondents: 54.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81244	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	20.00	
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	20.00	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	3.67	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.50	3.50
--	------	------

Urgency of medical decision making	2.67	3.50
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.33	3.17
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Physical effort required	3.17	3.17
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.83
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Outcome depends on the skill and judgment of physician	4.00	4.00
--	------	------

Estimated risk of malpractice suit with poor outcome	3.50	3.33
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.17	4.00
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Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWP/UT for 88291. This number

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 83912-26

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

CPT Code:81256 Tracking Number M13

Original Specialty Recommended RVU: **0.15**Presented Recommended RVU: **0.13**

Global Period: XXX

RUC Recommended RVU: **0.13**

CPT Descriptor: HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 38-year-old man is found to have elevated transferrin saturation (65%) and ferritin (800 ng/mL) on routine testing. The patient is otherwise healthy, and his family history is unremarkable. A sample of anticoagulated peripheral blood is submitted to the laboratory for testing for the HFE p. C282Y (c.845G>A) and p. H63D (c.187 C>G) hereditary hemochromatosis mutations.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated. The genomic regions containing the sites of the HFE p. C282Y (c.845G>A) and p. H63D (c.187 C>G) mutations are amplified by PCR and the amplicons are then subjected to melting curve analysis. The physician examines the melting curve plot of red and green fluorescent signals vs. temperature as well as the plot of the negative first derivatives of red and green fluorescent signals vs. temperature. Based on the analysis of these curves, and comparison to the results obtained with wild type and mutant controls, the physician determines the status of the p. C282Y (c.845G>A) and p. H63D (c.187 C>G) mutations and determines the patient's status as homozygous, heterozygous, or compound heterozygous for each of these mutations. He or she composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81256				
Sample Size:	450	Resp N:	18	Response: 4.0 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		18.00	50.00	100.00	287.50
Survey RVW:		0.30	0.37	0.37	0.40
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		2.00	5.00	7.00	12.00
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: XXX Global Code

CPT Code:	81256	Recommended Physician Work RVU: 0.13		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		7.00		
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
86320	XXX	0.37	RUC Time

CPT Descriptor Immuno-electrophoresis; serum**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95165	XXX	0.06	RUC Time	5,412,909
<u>CPT Descriptor 1</u> Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
73560	XXX	0.17	RUC Time	2,137,514

CPT Descriptor 2 Radiologic examination, knee; 1 or 2 views

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 10 % of respondents: 55.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81256	<u>Key Reference CPT Code:</u> 86320	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	7.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
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	7.00	17.00	
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	2.30	2.80
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.30	2.70
--	------	------

Urgency of medical decision making	2.20	2.70
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	2.80	3.00
--------------------------	------	------

Physical effort required	2.30	2.30
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.50	2.80
---	------	------

Outcome depends on the skill and judgment of physician	2.50	2.70
--	------	------

Estimated risk of malpractice suit with poor outcome	2.70	2.90
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	2.60	2.70
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWP/UT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.15.

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) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

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 College of American Pathologists How often? Sometimes

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	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

15,000 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	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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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

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. 83912-26

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

CPT Code:81270 Tracking Number M14

Original Specialty Recommended RVU: **0.22**Presented Recommended RVU: **0.15**

Global Period: XXX

RUC Recommended RVU: **0.15**

CPT Descriptor: JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year-old man presents with headache, dizziness and hypertension. A CBC reveals hemoglobin of 20 g/dL and platelet count of 600,000/ μ L. The physician is concerned that the patient may have a myeloproliferative disorder such as polycythemia vera. A sample of anticoagulated peripheral blood is submitted to the laboratory for JAK2 V617F mutation detection.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality DNA is isolated. Allele specific, real time PCR utilizing hydrolysis probes is performed to amplify a short region spanning the mutation site. Following amplification, genotyping is performed by allelic discrimination, using a mixture of two probes, one of which is specific for the wild type gene, and the other specific for the mutant gene. The physician examines a graphical display of the fluorescence signal for the patient's sample, compares the results to mutant and wild type controls, and determines the status of the JAK2 mutant allele. He or she composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81270				
Sample Size:	450	Resp N:	46	Response: 10.2 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	46.25	100.00	200.00
Survey RVW:		0.10	0.37	0.43	0.52
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		3.00	7.00	10.00	15.00
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
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:	81270	Recommended Physician Work RVU: 0.15		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
86320	XXX	0.37	RUC Time

CPT Descriptor Immunolectrophoresis; serum**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93010	XXX	0.17	RUC Time	19,334,268
<u>CPT Descriptor 1</u> Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 14 % of respondents: 30.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81270	<u>Key Reference CPT Code:</u> 86320	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	10.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
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	17.00	
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	2.57	2.86
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.93
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Urgency of medical decision making	3.07	3.07
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	3.07
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Physical effort required	2.07	2.36
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.07
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Outcome depends on the skill and judgment of physician	2.93	3.07
--	------	------

Estimated risk of malpractice suit with poor outcome	3.21	3.29
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INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	2.71	2.93
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Post-Service intensity/complexity	0.00	0.00
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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.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWPUT for 86320. This number

was compared to the survey 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.22.

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) The molecular stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

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 College of American Pathologists

How often? Sometimes

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	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?

15,000 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 0

Percentage 0.00 %

Specialty	Frequency 0	Percentage 0.00 %
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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

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. 83912-26

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

CPT Code:81275 Tracking Number M15

Original Specialty Recommended RVU: **0.50**Presented Recommended RVU: **0.50**

Global Period: XXX

RUC Recommended RVU: **0.50**

CPT Descriptor: KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis, variants in codons 12 and 13

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old male patient presents with fatigue and weight loss. A full history and physical was performed and blood is discovered in the stool. Gastrointestinal endoscopic examination is performed and a large mass lesion in the sigmoid colon is found. Biopsies are taken and demonstrate a moderately differentiated adenocarcinoma of colonic origin. Subsequent radiologic studies identify possible enlarged lymph nodes in the region of the mass lesion. A resection is performed and metastases are identified. KRAS mutation testing is ordered as the patient is a potential candidate for targeted therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 98%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: DNA is extracted from a tumor tissue sample. PCR is performed to detect KRAS mutations in a background of wild-type DNA in 8 separate reactions utilizing fluorescent probe-linked primers specific for each of the seven most common mutations in codons 12 and 13 of exon 2 of the KRAS gene, as well as a control reaction that amplifies a region of KRAS exon 4. The physician analyzes the fluorescent curves that are produced as the PCR products are generated for each reaction. The physician assesses the amplification of internal controls in each reaction and compares the difference between the crossing thresholds of the mutation assay and the control assay to the establish mutation status. The physician composes a report which specifies the mutation status of the patient's tumor and includes a comment on the implications of the lower limit of detection of the test relative to the tumor content of the sample. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81275				
Sample Size:	450	Resp N:	43	Response: 9.5 %	
Sample Type:	Convenience Additional Sample Information:				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	29.00	90.00	171.50	650.00
Survey RVW:	0.35	0.50	0.75	1.00	1.52
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	5.00	15.00	20.00	30.00	45.00
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: XXX Global Code

CPT Code:	81275	Recommended Physician Work RVU: 0.50		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88363	XXX	0.37	RUC Time

CPT Descriptor Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92250	XXX	0.44	RUC Time	2,175,839

CPT Descriptor 1 Fundus photography with interpretation and report

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92083	XXX	0.50	RUC Time	2,580,775

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 12 % of respondents: 27.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81275	<u>Key Reference CPT Code:</u> 88363	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	20.00	17.00	
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	20.00	17.00
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	3.50	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.42	3.25
Urgency of medical decision making	3.83	3.67

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.67
Physical effort required	3.42	3.25

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.58	3.33
Outcome depends on the skill and judgment of physician	3.58	3.42
Estimated risk of malpractice suit with poor outcome	3.42	3.42

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.67	3.58
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 15,000 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? 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

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. 83912-26

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

CPT Code:81291 Tracking Number M16

Original Specialty Recommended RVU: **0.22**Presented Recommended RVU: **0.15**

Global Period: XXX

RUC Recommended RVU: **0.15**

CPT Descriptor: MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 43-year-old man developed a right femoral venous thrombosis following a 3-hour airplane flight and subsequently developed pulmonary emboli. There was a vague history of other family members having “clotting problems.” His plasma homocysteine level was mildly elevated. A sample of anticoagulated peripheral blood is submitted to the laboratory for MTHFR c.677C>T and c.1298A>C mutation testing.

Percentage of Survey Respondents who found Vignette to be Typical: 63%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, high quality genomic DNA is isolated. The genomic regions containing the sites of the MTHFR c.677C>T and c.1298A>C variants are amplified by multiplex PCR and the resulting amplicons subjected to melting curve analysis. The physician examines the melting curve plots of red and green fluorescent signals vs. temperature as well as the negative first derivative plots of the melting curves. Based on this analysis and comparison of results with appropriate controls, the physician determines the zygosity status of the c.677C>T and c.1298A>C variants and composes a report specifying the patient’s genotype. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81291				
Sample Size:	450	Resp N:	16	Response:	3.5 %
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		15.00	52.50	125.00	243.75
Survey RVW:		0.30	0.34	0.37	0.44
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		4.00	5.00	10.00	13.00
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
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:	81291	Recommended Physician Work RVU: 0.15		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
86320	XXX	0.37	RUC Time

CPT Descriptor Immuno-electrophoresis; serum**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93010	XXX	0.17	RUC Time	19,334,268

CPT Descriptor 1 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 10 % of respondents: 62.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81291	<u>Key Reference CPT Code:</u> 86320	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	10.00	9.00	
Median Immediate Post-service Time	0.00	3.00	
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	17.00	
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	2.50	3.10
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	3.30
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Urgency of medical decision making	2.40	3.00
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.70	3.10
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Physical effort required	2.20	2.30
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.60	3.20
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Outcome depends on the skill and judgment of physician	2.70	3.10
--	------	------

Estimated risk of malpractice suit with poor outcome	2.76	3.40
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	2.80	3.10
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 86320. The committee calculated an RVU based on using the median survey time and IWP/UT for 86320. This number

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 83912-26

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

CPT Code:81315 Tracking Number M17

Original Specialty Recommended RVU: **0.39**Presented Recommended RVU: **0.37**

Global Period: XXX

RUC Recommended RVU: **0.37**

CPT Descriptor: PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old previously healthy man presented to his physician complaining of fatigue, weakness, dyspnea, and easy bruising. He was found to have an elevated white blood count, anemia, and severe thrombocytopenia. The peripheral blood smear demonstrated large numbers of promyelocytes. Laboratory studies indicated DIC was present. The patient was emergently started on all trans-retinoic acid an anthracycline and supportive therapy for his coagulopathy. Bone marrow aspiration was performed, cytogenetic studies were ordered, and anticoagulated marrow was immediately sent to the laboratory for PML/RARalpha translocation testing by quantitative real-time PCR.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, total RNA is isolated and assessed for quality. Quantitative real-time reverse transcriptase PCR is performed in three separate tubes to detect and quantify the bcr1, bcr2, and bcr3 breakpoints as well as the Abelson gene (ABL1) in each tube. The physician analyzes the blue fluorescent curves that are produced as the PCR products are generated to determine the status of the translocation. He or she relates the crossing threshold to previously generated standard curves for the PML-RARA and ABL transcripts to determine the normalized and absolute copy numbers of the PML-RARA transcripts present in the specimen at the time of testing. The physician composes a report that describes the transcript status, the specific isoform, and the normalized copy number. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81315				
Sample Size:	450	Resp N:	27	Response: 6.0 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		6.00	20.00	40.00	50.00
Survey RVW:		0.20	0.51	0.52	0.61
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		3.00	8.00	15.00	23.00
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
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:	81315	Recommended Physician Work RVU: 0.37		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		15.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.31	RUC Time	1,231,072

CPT Descriptor 1 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 12 % of respondents: 44.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81315	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	15.00	20.00	
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	15.00	20.00	

Other time if appropriate		
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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	3.67	3.67
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.92	4.00
--	------	------

Urgency of medical decision making	4.58	3.92
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.83	4.08
--------------------------	------	------

Physical effort required	3.08	3.17
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.67	4.08
---	------	------

Outcome depends on the skill and judgment of physician	4.17	3.83
--	------	------

Estimated risk of malpractice suit with poor outcome	4.25	3.67
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.67	3.83
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

Specialty	Frequency	Percentage	%
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

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. 83912-26

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

CPT Code:81316 Tracking Number M18

Original Specialty Recommended RVU: **0.31**Presented Recommended RVU: **0.22**

Global Period: XXX

RUC Recommended RVU: **0.22**

CPT Descriptor: PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Quantitative PCR testing is requested on a 45-year-old man with an established diagnosis of acute promyelocytic leukemia to assess for treatment effectiveness and disease relapse. Anticoagulated marrow is sent to the laboratory for PML/RARalpha translocation testing for the previously identified breakpoint by quantitative real-time PCR.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: Upon receipt of the specimen, total RNA is isolated and assessed for quality. Quantitative real-time reverse transcriptase PCR is performed to detect and quantify the patient's specific breakpoint and the Abelson gene (ABL1). The physician analyzes the blue fluorescent curves that are produced as the PCR products are generated to determine the status of the translocation. He or she relates the crossing threshold to previously generated standard curves for the PML-RARA and ABL transcripts to determine the normalized and absolute copy numbers of the PML-RARA transcript present in the specimen at the time of testing. The physician composes a report that describes the transcript status and the normalized copy number, and compares these breakpoint specific results with the patient's previous results. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81316				
Sample Size:	450	Resp N:	15	Response: 3.3 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	13.50	30.00	45.00
Survey RVW:		0.20	0.37	0.45	0.57
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	8.00	12.00	18.00
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: XXX Global Code

CPT Code:	81316	Recommended Physician Work RVU: 0.22		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		12.00		
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 6 % of respondents: 40.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81316	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	12.00	20.00	
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	12.00	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	3.83	3.67
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.83	3.50
--	------	------

Urgency of medical decision making	4.33	3.67
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.83	3.50
--------------------------	------	------

Physical effort required	3.50	3.33
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.17	3.83
---	------	------

Outcome depends on the skill and judgment of physician	3.83	3.67
--	------	------

Estimated risk of malpractice suit with poor outcome	3.67	3.17
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.83	3.67
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

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.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number

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

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. 83912-26

CPT Code: Tier 1 (81200-81330) and Tier 2 (81400-81408)
AMA Specialty Society RVS Update Committee Recommendation

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

Meeting Date: April 2011

Global Period: XXX

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

CAP distributed practice expense surveys to various laboratories throughout the country, assuring that laboratories in various practice settings and sizes were included. The molecular pathologists and their lab managers (when applicable) submitted detailed practice expense recommendations to CAP for clinical labor, supplies, equipment and typical national batch size as well as the batch size in their particular laboratory.

CAP convened an expert panel, comprised of several molecular pathologists, members of the Economic Affairs Committee and the RUC subcommittee. The expert panel reviewed all the recommendations received. The panel adjusted the recommendations to adhere to applicable MoPath standards (i.e. confirm order, accession, extraction, set up, post time, etc). The panel also reviewed all the batch size data collected. The panel then made adjustments to clinical times, supplies and equipment based on batch size.

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

We did not use a comparison code for these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical activities for these molecular pathology codes often fall into several broad subcategories. They include (when applicable):

- Confirm Orders
- Accession
- Extraction
- Set Up
- Gel
- Post Processing
- Review and Prepare

CPT Code: Tier 1 (81200-81330) and Tier 2 (81400-81408)
AMA Specialty Society RVS Update Committee Recommendation

To facilitate review by the PEAC committee, we included broad categories of activities on the excel sheets. During our presentation we are prepared to walk the committee through the detail for each procedure, as requested. Although the activities fall into broad categories, the order and terminology is often different.

Below is a summary of our recommendations:

Tier	CPT Code	CPT Code Descriptor	Batch Size	Rec Times
Tier 1	BXXX2	<i>BCR/ABL 1; major breakpoint</i>	2	146
	BXXX3	<i>BCR/ABL 1; minor breakpoint</i>	1	176
	BXXX4	<i>BCR/ABL 1; other breakpoint</i>	1	176
	CXXX1	<i>CFTR (cystic fibrosis); common variants</i>	5	40
	CXXX2	<i>CFTR (cystic fibrosis); known familial variants</i>	1	211
	CXXX3	<i>CFTR (cystic fibrosis); duplication/deletion variants</i>	1	237
	CXXX4	<i>CFTR (cystic fibrosis); full gene sequence</i>	1	345
	CXXX5	<i>CFTR (cystic fibrosis); intron 8 poly-T analysis</i>	5	66
	FXXX1	<i>F2 gene analysis; 20210G>A variant</i>	5	39
	FXXX2	<i>F5 gene analysis; Leiden variant</i>	5	39
	FXXX4	<i>FMRI (Fragile X mental retardation 1) gene analysis; evaluation to detect abnormal alleles</i>	5	67
	FXXX5	<i>FMRI (Fragile X mental retardation 1) gene analysis; characterization of alleles</i>	1	174
	HXXX2	<i>HFE gene analysis; common variants</i>	5	68
	JXXX1	<i>JAK2 gene analysis; V617F variant</i>	3	116
	KXXX1	<i>KRAS gene analysis; variants in codons 12 and 13</i>	3	170
	MXXX2	<i>MTHFR gene analysis; common variants</i>	2	141
	PXXX1	<i>PML/RARalpha translocation analysis; common breakpoints</i>	1	150
	PXXX2	<i>PML/RARalpha translocation analysis; single breakpoints</i>	1	150

CPT Code: Tier 1 (81200-81330) and Tier 2 (81400-81408)
AMA Specialty Society RVS Update Committee Recommendation

Tier	CPT Code	CPT Code Descriptor	Batch Size	Rec Times
Tier 2	L2XX1	<i>Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)</i>	2	89
	L2XX2	<i>Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)</i>	2	141
	L2XX3	<i>Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)</i>	2	182
	L2XX4	<i>Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicon using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)</i>	2	205
	L2XX5	<i>Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)</i>	1	217
	L2XX6	<i>Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)</i>	1	228
	L2XX7	<i>Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)</i>	1	250
	L2XX8	<i>Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)</i>	1	355
	L2XX9	<i>Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)</i>	1	455

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- Enter results in lab information system after physician interpretation.
- Prepare, pack and transport specimens and records for in-house storage and external storage

CPT Code: Tier 1 (81200-81330) and Tier 2 (81400-81408)
AMA Specialty Society RVS Update Committee Recommendation

- Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste
- Clean Room
- Perform station maintenance including system rinse and dry
- Perform scheduled data management back-up



April 20, 2011

Sherry L. Smith, MS, CPA
Director
Physician Payment Policy and Systems
American Medical Association
515 North State Street
Chicago, Illinois 60654

Dear Ms. Smith,

This letter is in follow up to our conversation from last week in which we discussed some of the concerns of the RUC's Practice Expense Subcommittee concerning the molecular pathology codes.

One area of concern of the subcommittee members pertained to who was involved in determining the practice expense inputs. From our molecular experts, we compiled a list of laboratories for each code that performed the various assays. The expert panel then selected one laboratory to recommend practice expense inputs for each code. The laboratories selected represented a full spectrum of laboratory sizes as well as practice types. Academic institutions as well as large commercial laboratories were also included in the laboratories that provided inputs. Each laboratory also indicated to us what their typical batch size was and also recommended a typical batch size for all laboratories performing the test for that code.

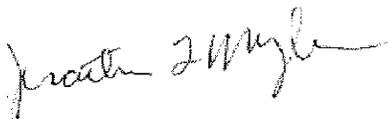
CAP's expert committee, which included members of our RBRVS workgroup as well as molecular experts, reviewed the practice expense inputs and batch sizes. Many of the steps are similar in various codes and allowed comparisons to be made. The batch sizes recommended to the RUC's Practice Expense Subcommittee from CAP were significantly larger than that recommended by the laboratories and the times for each step were typically a fraction of what the laboratory recommended.

In follow up to the Practice Expense Subcommittee's question concerning frequency, I indicated that in the existing coding scheme, it is not possible to reliably determine frequency data for the various codes. In fact, the AMA-CPT molecular pathology workgroup did investigate obtaining frequency data over a period of two years and ultimately concluded that reliable frequency data could not be obtained. Many laboratories would provide generalized percent distribution data, but would not provide specific numbers. However, the committee did conclude that the overwhelming highest volume test in frequency for molecular pathology was cystic fibrosis testing. This may not be applicable to the Medicare population. From review of the ICD 9 codes for the current way the professional services are coded (with CPT code 83912), it is not possible to reliably determine the frequency of molecular pathology codes under review. However, in our previous conversation, you indicated that the AMA would be willing to work with us using additional data available to the AMA to assist CAP in attempting to make this determination. For subcommittee guidance, anything with a batch size greater than two for any code listed in Tier 1 would be one of the higher frequency codes. Tier 2 codes are anticipated to be less than ten percent of total billed molecular pathology services and will not be considered high frequency codes. The batch size was increased in levels 1 through 4 to reduce times and maintain rank order with the rest of the Tier 2 codes.

College of American Pathologists

I hope these comments have been helpful to you. Please do not hesitate to contact me if you have any questions.

Cordially,

A handwritten signature in black ink that reads "Jonathan L. Myles". The signature is written in a cursive style with a long horizontal stroke at the end.

Jonathan L. Myles, MD, FCAP
RUC Advisor
College of American Pathologists

jlM/kmc
Sent via email

Revised Total Clinical Labor time Tabs 15 and 16

AMA Specialty Society RVS Update Committee Recommendation

Tab 16: Tier 2 Codes				
CPT Code	Original Rec Time	Revised Rec Time	Original Batch Size	Revised Batch Size
81400	89	53	2	4
81401	141	75	2	4
81402	182	83	2	4
81403	205	102	2	4
81404	217	109	1	2
81405	228	118	1	2
81406	250	129	1	2
81407	355	158	1	2
81408	455	199	1	2
Tab 15: Tier 1 Codes				
81206	146	93	2	2
81207	176	86	1	2
81208	176	86	1	2
81220	40	29	5	10
81221	211	109	1	2
81222	237	107	1	2
81223	345	155	1	2
81224	66	29	5	10
81240	39	32	5	8
81241	39	32	5	8
81243	67	45	5	8
81244	174	80	1	2
81256	68	28	5	8
81270	116	37	3	5
81275	170	44	3	5
81291	141	64	2	4
81315	150	93	1	2
81316	150	93	1	2

	A	B	C	D	E	F
1	AMA Specialty Society RVS Update Committee Recommendation			81206	81207	81208
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for batch size - 2</i>			<i>BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative</i>	<i>BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative</i>	<i>BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative</i>
3		CMS Code	Staff Type	Minutes	Minutes	Minutes
4	Global Period			XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME			93	86	86
6	<i>Lab Tech</i>	L033A		18	18	18
7	<i>Cytotechnologist</i>	L045A		75	68	68
8	TOTAL PRE-SERV CLINICAL LABOR TIME			82	74	74
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME					
10	TOTAL POST-SERV CLINICAL LABOR TIME			11	11	11
11	PRE-SERVICE					
12	Start: When preparing containers/requisitions for physician begins					
13	Confirm orders	L033A	Lab Tech	1	1	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6	6
15	Perform White Cell Count to prepare for RNA Extraction	L045A	Cytotechnologist	2	2	2
16	Reagent preparation for RT, pcr, CE	L045A	Cytotechnologist	7	7	7
17	Remove Buffy Coat	L045A	Cytotechnologist	2	2	2
18	Red Cell Lysis	L045A	Cytotechnologist	6	6	6
19	RNA Extraction Trizol method	L045A	Cytotechnologist	12	12	12
20	Perform OD / Calculate Quantity	L045A	Cytotechnologist	3	3	3
21	Gel Preparation and load QC Gel to confirm quality RNA	L045A	Cytotechnologist	9	9	9
22	cDNA Synthesis / Reverse Transcription	L045A	Cytotechnologist	10	10	10
23	Prepare worksheet to set up pcr / calculate mastermix, cDNA, etc.	L045A	Cytotechnologist	3	3	3
24	Set Up PCR	L045A	Cytotechnologist	9	9	9
25	Load Real time instruments	L045A	Cytotechnologist	2	0	0
26	Dilute Sample twice to prepare for capillary electrophoresis	L045A	Cytotechnologist	5	0	0
27	Load on Capillary Electrophoresis to identify transcript type	L045A	Cytotechnologist	2	2	2
28	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2	2	2
29	End: When specimen is ready for examination by physician					
30	Service Period					
31				None		
32	Post-Service Period					
33	Start: When specimen examination by physician is complete					
34	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2	2
35	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2	2
36	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2	2
37	Clean Room	L033A	Lab Tech	2	2	2
38	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2	2
39	Perform scheduled data management back-up	L033A	Lab Tech	1	1	1
40	End: When specimen, chemical waste and record handling is complete					
41	SUPPLIES		Type of Unit	No. of Units	No. of Units	No. of Units
42	RNA isolation kit		kit	0.04	0.04	0.04
43	Gown	SB027	item	2	2	2
44	Gloves		pair	5	5	5
45	Bleach 10%	SL020	ml	5	5	5
46	1.5 ml tube		each	4	4	4
47	100 ml TAE Buffer		ml	100	100	100
48	10mM dNTPs		ul	7	7	7
49	2 Forward Primers		ul	16	16	16
50	5x Buffer		ul	13	13	13
51	96 well plate (2)		each	4	4	4
52	ABL Probe		ul	1	1	1
53	Agarose		Gram	1	1	1
54	bcr/abl Probe		ul	1	1	1
55	Blue Gel Dye		ul	9	9	9
56	CST ROX Size standard		ul	0.2	0	0
57	DEPC treated water		ul	30	30	30
58	Disposable lab coat x 2		each	2	2	2
59	Ethidium Bromide		ul	5	5	5
60	Eye Shield	SM016	each	1	1	1
61	Formamide x 2		ul	20	0	0
62	Internal Control Forward Primer		ul	0.5	0.5	0.5
63	Internal Control Reverse Primer		ul	0.5	0.5	0.5
64	Random hexamers		ul	7	7	7
65	Reverse Primers		ul	8	8	8
66	RNASse 40 u/ul		ul	1	1	1
67	Running Buffer		ul	80	0	0
68	Superscript		ul	2	2	2
69	Tips		pack	1	1	1
70	Tubes		each	10	10	10
71	Universal Master Mix		ul	25	25	25
72						
73	Equipment			Time in Use Minutes	Time in Use Minutes	Time in Use Minutes
74	Analytical balance	EP004		1	1	1
75	Capillary electrophoresis instrument, fragment analysis			30	0	0
76	Centrifuge	EP059		3	3	3
77	Cooling block			3	3	3
78	Gel electrophoresis apparatus with power supply	EP063		15	15	15
79	Gel imaging system	EP062		4	4	4
80	Nucleic acid extraction Instrument			9	9	9
81	Nucleic acid workstation			15	15	15
82	Pipet Set	E071		25	25	25
83	Real-time PCR instrument			23	23	23
84	Thermal cycler			30	30	30
85	Water bath	EP043		10	10	10

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		81220	
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 10</i>		CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)	
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			29
6	Lab Tech	L033A		16
7	Cytotechnologist	L045A		13
8	TOTAL PRE-SERV CLINICAL LABOR TIME			20
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			9
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	Receiving sample, checking for unacceptable conditions: clotted or frozen, serum, severely hemolyzed samples			
16	Create patient list for testing			
17	Family history entry and check, to determine if there is known familial mutations requested			
18	EXTRACTION	L045A	Cytotechnolog	4
19	Extraction Set up: prepare load list on instrument, print work list and label, resolve all specimen discrepancies and label specimen tubes accordingly, preparing sample extraction reagents			
20	Load extraction reagents, micro particles, etc in reagents vessels on the instrument, put samples in the sample rack and load onto m2000sp			
21	Instrument Clean up after extraction is completed: bleach sample racks, wipe with bleach workbench on m2000sp, clean up reaction wells, reagent vessel holders			
22	PCR / OTHER PROCESSES	L045A	Cytotechnolog	4
23	Collect all PCR Master mix reagents, thaw; Fill out Master mix worksheet to calculate reagent needed for the number of samples in the run; Prepare master mix for the run,			
24	Label PCR tubes for patients and controls; Pipette patient samples into prepared PCR tubes; Preparing PCR plate by aliquoting Master mix into each sample tube/well. Seal PCR plate/tube, put in cyclor and run PCR program			
25	Set up Amplicon Treatment reagent and pipette to PCR Plate			
26	Prepare ASPE master mix worksheet and calculate reagent amount for the number of samples; Prepare multiplex ASPE Primer mix and ASPE master mix			
27	Aliquot ASPE master mix into each sample tube/well. Seal the Plate, and put back into cyclor and run ASPE program on the cyclor			
28	Work list prep			
29	DETECTION / HYBRIZATION	L045A	Cytotechnolog	3
30	Luminex Set up, turn on instrument, check fluid levels in the sheath fluid box and waster reservoir, change if needed; Collect beads and prepare 1X wash buffer for bead hybridization;			
31	Add beads to samples post ASPE reaction, seal plates and hybridization in cyclor for 1 Hybridization to beads, wash with wash buffer using vacuum manifold, repeat wash for a second time			
32	Add SA-PE conjugate to the samples post bead hybridization and wash.			
33	Data acquisition on Luminex analyzer: setting up instrument run, reagent lot number, Prepare tray map on Luminex 200, enter patient samples IDs and controls; adjust probe height, flush instrument, load plate and run			
34	Review sample and prepare data for physician interpretation	L045A	Cytotechnolog	2
35	End: When specimen is ready for examination by physician			
36	Post-Service Period			
37	Start: When specimen examination by physician is complete			
38	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
39	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	1
40	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
41	Clean Room	L033A	Lab Tech	1
42	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
43	Perform scheduled data management back-up	L033A	Lab Tech	1
44	End: When specimen, chemical waste and record handling is complete			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		81220	
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 10</i>		<i>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)</i>	
3		CMS Code	Staff Type	Minutes
45	SUPPLIES		Type of Unit	No. of Units
46	0.2 ml PCR tube		item	6
47	1.5ml tubes	SL240	item	2
48	Bleach	SL020	mL	1
49	Blood collection (6mL, purple top)	SL242	unit	1
50	DNA extraction instrument pipette tips		item	42
51	DNA extraction instrument reagent kit		reaction	1
52	gloves, non-sterile, nitrile	SB023	item	1
53	High fidelity taq polymerase		µL	2
54	Labels		item	27
55	Microseal		item	1
56	Multichannel pipette tips		item	3
57	Multiplates		item	1
58	optical Ind Flat 8/cap strip		item	1
59	Paper		item	6
60	PCR and APSE WATER	SL2521	µL	24
61	Pipette tips, 100ul		item	3
62	Pipette tips, 10ul		item	7
63	Pipette tips, 200ul		item	3
64	Pipette tips, 30ul		item	3
65	Synthetic Super Control		item	1
66	xMAP Sheath Fluid		L	1
67	xTAG CF reagent kit		item	1
68				
69	Equipment			Time in Use Minutes
70	Centrifuge		EP059	9
71	Cooling block			3
72	Luminex Instrument			3
73	Micro-volume spectrophotometer with specimen retention technology			1
74	Nucleic acid extraction instrument			5
75	Nucleic acid workstation			4

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81221
2	Meeting Date: April 2011 Specialty: Pathology <i>Typical Batch Size - 2</i>			<i>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants</i>
3		CMS Code	Staff Type	Total Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			109
6	<i>Lab Tech</i>			<i>18</i>
7	<i>Cytotechnologist</i>			<i>91</i>
8	TOTAL PRE-SERV CLINICAL LABOR TIME			98
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	sort and rack specimen according to test requested			
17	place blood sample on rocker			
18	Place tips and microtiter plate on Qiagen 9604			
19	Remove cap from blood tube			
20	place blood sample in Qiagen 9604 rack and allow instrument to read bar code and aliquot blot into microtiter plate			
21	Create plate map for testing and IT interface			
22	Cap blood tube and return specimen to refrigerator until testing completed			
23	Place tips, reagents and microtiter plates on Qiagen M96			
24	Place microtiter plate with blood sample on Qiagen M96			
25	discard DNA extraction waste (liquids and solids)			
26	PCR Set Up			13
27	Assemble PCR Primers, buffer, etc... into plates			
28	combine reagents for PCR master mix			
29	Place tips, PCR reagents and PCR reaction plate on Biomek 2000			
30	Remove extracted DNA from Qiagen M96 and place on Biomek 2000			
31	Allow instrument to set up PCR reaction			
32	Cover plate with sealing mat			
33	discard Biomek 2000 tips from PCR set up			
34	Place PCR reaction plate in ABI 9700 thermal cycler, enter CF PCR program, and allow instrument to perform multiplex PCR			
35	Cover plate with sealing mat			
36	discard Biomek 2000 tips from PCR set up			
37	Gel Check	L045A	Cytotechnologist	13
38	Spin down PCR plate (Gel Check)			
39	Combine 2ul of Sample with 10 ul water (Gel Check)			
40	Add samples to E-Gel			
41	Photograph Gel			
42	Save Image and Annotate			
43	PCR Post Processing 1	L045A	Cytotechnologist	17
44	Create CIAP/EXO Mix			
45	Add Mix to plate			
46	Add samples to mix			
47	Place on 9700 Cycler			
48	Dye Term Cycle	L045A	Cytotechnologist	13
49	Prepare Sequencing plates			
50	Prepare Sequencing Big Dye Master Mix			
51	Aliquot Big Dye master mix			
52	Add template			
53	Seal, vortex, spin			
54	Place on 9700 Cycler			
55	Dye Term Clean Up	L045A	Cytotechnologist	24
56	Make fresh Sodium Acetat/ETOH			
57	Add to Sequencing Samples			
58	Spin Down for 20 min			
59	Invert plate on towels			
60	Quick spin plate			
61	Make fresh 70% ETOH			
62	Add ETOH to wells			
63	Spin for 5 min			
64	Quick spin plate			
65	Add Hi Di and Seq Standard			
66	Add Hi Di and Seq Standard			
67	Ensure sequencer is ready to load by changing buffers, water, and waste. Make sure "OUT" stack is empty			
68	Sequencing	L045A	Cytotechnologist	5
69	Load plate onto sequencer			
70	Create new sample sheet using batch name/sample number			
71	Check capillary array after run is completed			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81221
2	Meeting Date: April 2011 Specialty: Pathology Typical Batch Size - 2			CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants
3		CMS Code	Staff Type	Total Minutes
72	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
73	End: When specimen is ready for examination by physician			
74	Service Period			
75				
76	Post-Service Period			
77	Start: When specimen examination by physician is complete			
78	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
79	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
80	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
81	Clean Room	L033A	Lab Tech	2
82	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
83	Perform scheduled data management back-up	L033A	Lab Tech	1
84	End: When specimen, chemical waste and record handling is complete			
85	SUPPLIES		Type of Unit	No. of Units
86	DNA isolation kit		reaction	1
87	Gown	SB027	item	1
88	Gloves, nonsterile	SB022	pair	5
89	Bleach 10%	SL020	ml	1.5
90	High fidelity hot start Taq polymerase		ul	0.5
91	PCR buffer		ul	10
92	MgCl2		ul	3
93	F Primer		ul	2
94	R Primer		ul	2
95	dNTPs		ul	2
96	PCR grade water	SL244	ul	68
97	Ethidium bromide (10 mg/ml)	SL239	ul	5
98	DNA ladder, 100bp		ul	5
99	Loading buffer with dye	SL210	ul	20
100	Agarose ultrapure		g	0.8
101	Agarose NuSieve GTG		g	1.6
102	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
103	Masking tape		inch	12
104	96 Capillary array		item	1/200
105	Cycle sequencing kit		ul	16
106	Cycle sequencing purification plates		each	1
107	Optical 96 well reaction plate		each	1
108	Sequencing primers		ul	4
109	0.2 ml strip tubes		each	1
110	0.2 ml PCR tubes		each	2
111	Barrier pipet tips 1000 uL		ul	1
112	Barrier pipet tips 200 uL		each	3
113	Barrier pipet tips 20uL		each	15
114	Milli-Q water		ml	35
115	Exonuclease I / Shrimp alkaline phosphatase		ul	4
116	Formamide	SL192	ul	30
117	Septa		each	0.3
118	Polymer		ul	1/125
119	Sequencing cassette		each	1
120	Running buffer		ul	80
121	15 mL centrifuge tubes	SL241		2
122	50 mL centrifuge tubes			2
123	2 mL plastic tubes		each	1
124	0.5 mL microcentrifuge tubes			2
125	Extraction tubs		each	4
126	Extraction tip assembly		each	1
127				
128	Equipment			Time in Use Minutes
129	Analytical balance		EP004	1
130	Capillary electrophoresis instrument, 96 well - sequencing			12
131	Centrifuge		EP059	3
132	Cooling block			3
133	Gel electrophoresis apparatus with power supply		EP063	15
134	Gel imaging system		EP062	4
135	Micro-volume spectrophotometer with specimen retention technology			1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81222
	Meeting Date: April 2011 Specialty: Pathology			<i>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants</i>
2	Typical Batch Size - 2			
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			107
6		Lab Tech L033A		18
7		Cytotechnologist L045A		89
8	TOTAL PRE-SERV CLINICAL LABOR TIME			96
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	sort and rack specimen according to test requested			
17	place blood sample on rocker			
18	Place tips and microtiter plate on Janus PE			
19	Remove cap from blood tube			
20	Check the reagent levels.			
21	Check the waste container level.			
22	Verify availability of all necessary disposables			
23	Write ID # in the input tube (red cap) and output tube (blue cap).			
24	Confirm that Autopure LS, and computer are powered on.			
25	Confirm the system waste bottle is not full.			
26	Verify ID number on sample tube matches ID number on aliquot tube and transfer blood to input tube.			
27	Place samples into appropriate position in sample racks and verify that the input tube matches the output tube.			
28	Place sample racks into appropriate position on deck surface of Autopure LS.			
29	Enter user ID, password and log on.			
30	Initialize and Prime for the reagents			
31	On main menu start your run by clicking on "set up rack" and follow through.			
32	Enter the ID # for input and output tubes on the computer.			
33	Click on "select rack" and "start run".			
34	After run, remove tubes from Autopure, discard input tubes			
35	Place output tubes in 65°C incubator for 1 hr			
36	Remove tubes, place them on a platform to rotate overnight at room temperature			
37	Place DNA output tubes in numerical order			
38	Transfer DNA to labeled 1.5 ml tubes.			
39	Pipette with 1ml pipette tip to completely dissolve DNA			
40	Quant on Fluorometer or Spectramax. Remix, dilute and requant as necessary.			
41	Label side of tube with quant			
42	Place DNA in appropriate box.			
43	discard DNA extraction waste (liquids and solids)			
44	PCR Set Up	L045A	Cytotechnologist	28
45	Place tips, PCR reagents and PCR reaction plate into the hood. Prepare the PCR master mix.			
46	Add the master mix to the reagent plate			
47	Using extracted DNA make necessary dilutions			
48	Add extracted DNA & control per well per sample			
49	Set up PCR reaction			
50	Cover plate with sealing mat, vortex and spin down in the plate centrifuge			
51	Place PCR reaction plate in ABI 9700 thermal cycler, enter CFDel/Dup PCR program, and allow instrument to perform multiplex PCR			
52	PCR Post Processing	L045A	Cytotechnologist	55
53	Pull the PCR reaction plate out of ABI 9700 thermal cycler to be stored or to proceed with next step			
54	Pull the loading mix reagents (HiDi Formamide and GeneScan 350 ROX Size Standard) out of the freezer, let them thaw out			
55	Make the loading mix by combining HiDi formamide and GeneScan 350 ROX Size Standard			
56	Spin down a PCR plate			
57	Add a loading mix into each well of an ABI optical plate			
58	Add pcr product to each well			
59	Cover the plate with septa and vortex the loading tray, and then spin down in the plate centrifuge.			
60	Place the plate in 95°C heat block for 5 minutes, then place on ice until use			
61	Prepare 3100 instrument for capillary electrophoresis (upload plate map, add buffer, POP6, capillary array, 16-well septa)			
62	Generate the plate record with template in Excel			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81222
	Meeting Date: April 2011 Specialty: Pathology			<i>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants</i>
2	<i>Typical Batch Size - 2</i>			
3		CMS Code	Staff Type	Minutes
63	Configure the plate in 3100 collection software with the run parameters, start the run			
64	Allow instrument to perform capillary electrophoresis			
65	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
66	End: When specimen is ready for examination by physician			
67	Service Period			
68				
69	Post-Service Period			
70	Start: When specimen examination by physician is complete			
71	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
72	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
73	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
74	Clean Room	L033A	Lab Tech	2
75	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
76	Perform scheduled data management back-up	L033A	Lab Tech	1
77	End: When specimen, chemical waste and record handling is complete			
78	SUPPLIES		Type of Unit	No. of Units
79	DNA isolation kit		reaction	1
80	10% bleach solution	SL020	ml	1.5
81	100% ethanol	SL189	ml	0.44
82	10x Buffer		ul	0.007
83	1-30ul pipet tips		each	5
84	16-well reservoir septa		each	0.06
85	25 mL pipettes		item	1
86	8-cap strips		each	0.13
87	8-strip tubes/caps		each	0.035
88	96-well septa		each	0.01
89	Barrier pipet 1000 tips		each	1
90	Barrier pipet 200 tips		each	2
91	cap for blood tube		each	1
92	Capillary array		item	1
93	DNA extraction instrument tips		item	6
94	DNA/RNase-free H2O	SL251	ul	20
95	Formamide	SL192	ml	0.012
96	gloves, nonsterile	SB022	item	1
97	gown, staff, impervious	SB027	item	0.5
98	green microtiter plates		each	0.01
99	High fidelity taq polymerase fast start		ul	0.2
100	High fidelity taq polymerase hot start		ul	0.1
101	Liquid handling system tips		item	1
102	Matrix Standard		ul	0.56
103	OLIGOs for PCR		item	30
104	optical plates, 96-well		each	0.02
105	PCR plates		each	0.01
106	Pipet Ser Dsp 10X1/10MI		item	1
107	Polymer		ul	10
108	sealing mat		each	0.01
109	Titer Tops plate sealers		item	0.011
110	U bottom microtiter plates		each	0.01
111	yellow microtiter plates		each	0.01
112				
113	Equipment			Time in Use Minutes
114	Capillary electrophoresis fragment analysis software			30
115	Capillary electrophoresis instrument, fragment analysis			30
116	Centrifuge		EP059	3
117	Cooling block			3
118	Micro-volume spectrophotometer with specimen retention technology			1
119	Nucleic acid extraction instrument			5
120	Nucleic acid workstation			28

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81223
	Meeting Date: April 2011			<i>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence</i>
2	<i>Typical Batch Size - 2</i>			
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			155
6	<i>Lab Tech</i>	L033A		18
7	<i>Cytotechnologist</i>	L045A		137
8	TOTAL PRE-SERV CLINICAL LABOR TIME			144
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	6
16	sort and rack specimen according to test requested			
17	place blood sample on rocker			
18	Place tips and microtiter plate on Qiagen 9604			
19	Remove cap from blood tube			
20	place blood sample in Qiagen 9604 rack and allow instrument to read bar code and aliquot blot into microtiter plate			
21	Create plate map for testing and IT interface			
22	Cap blood tube and return specimen to refrigerator until testing completed			
23	Place tips, reagents and microtiter plates on Qiagen M96			
24	Place microtiter plate with blood sample on Qiagen M96			
25	discard DNA extraction waste (liquids and solids)			
26	Assemble PCR Primers, buffer, etc... into plates			
27	combine reagents for PCR master mix			
28	PCR Set Up	L045A	Cytotechnologist	36
29	Place tips, PCR reagents and PCR reaction plate on Biomek 2000			
30	Remove extracted DNA from Qiagen M96 and place on Biomek 2000			
31	Allow instrument to set up PCR reaction			
32	Cover plate with sealing mat			
33	discard Biomek 2000 tips from PCR set up			
34	Place PCR reaction plate in ABI 9700 thermal cycler, enter CF PCR program, and allow instrument to perform multiplex PCR			
35	Cover plate with sealing mat			
36	discard Biomek 2000 tips from PCR set up			
37	Gel Check	L045A	Cytotechnologist	20
38	Spin down PCR plate (Gel Check)			
39	Combine 2ul of Sample with 10 ul water (Gel Check)			
40	Add samples to E-Gel			
41	Photograph Gel			
42	Save Image and Annotate			
43	PCR Post Processing 1	L045A	Cytotechnologist	18
44	Create CIAP/EXO Mix			
45	Add Mix to plate			
46	Add samples to mix			
47	Place on 9700 Cyclor			
48	Dye Term Cycle	L045A	Cytotechnologist	20
49	Prepare Sequencing plates			
50	Prepare Sequencing Big Dye Master Mix			
51	Aliquot Big Dye master mix			
52	Add template			
53	Seal, vortex, spin			
54	Place on 9700 Cyclor			
55	Dye Term Clean Up	L045A	Cytotechnologist	30
56	Make fresh Sodium Acetat/ETOH			
57	Add to Sequencing Samples			
58	Spin Down for 20 min			
59	Invert plate on towels			
60	Quick spin plate			
61	Make fresh 70% ETOH			
62	Add ETOH to wells			
63	Spin for 5 min			
64	Quick spin plate			
65	Add Hi Di and Seq Standard			
66	Cover with Septa/Quick Spin			
67	Ensure sequencer is ready to load by changing buffers, water, and waste. Make sure "OUT" stack is empty			
68	Sequencing	L045A	Cytotechnologist	5
69	Load plate onto sequencer			
70	Create new sample sheet using batch name/sample number			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81223
	Meeting Date: April 2011			<i>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence</i>
2	Typical Batch Size - 2			
3		CMS Code	Staff Type	Minutes
71	Check capillary array after run is completed			
72	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
73	End: When specimen is ready for examination by physician			
74	Service Period			
75				
76	Post-Service Period			
77	Start: When specimen examination by physician is complete			
78	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
79	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
80	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
81	Clean Room	L033A	Lab Tech	2
82	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
83	Perform scheduled data management back-up	L033A	Lab Tech	1
84	End: When specimen, chemical waste and record handling is complete			
85	SUPPLIES		Type of Unit	No. of Units
86	DNA isolation kit		reaction	1
87	Gown	SB027	item	1
88	Gloves, nonsterile	SB022	pair	5
89	Bleach 10%	SL020	ml	1.5
90	High fidelity hot start Taq polymerase		ul	13.5
91	PCR buffer		ul	270
92	MgCl2		ul	81
93	F Primer X 27		ul	2
94	R Primer X 27		ul	2
95	dNTPs		ul	54
96	PCR grade water	SL244	ul	1836
97	Ethidium bromide (10 mg/ml)	SL239	ul	10
98	DNA ladder, 100bp		ul	10
99	Loading buffer with dye	SL210	ul	40
100	Agarose ultrapure		g	1.6
101	Agarose NuSieve GTG		g	3.2
102	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	200
103	Masking tape		inch	24
104	96 Capillary array		item	1/200
105	Cycle sequencing kit		ul	432
106	Cycle sequencing purification plates		each	1
107	Optical 96 well reaction plate		each	1
108	Sequencing primers		ul	108
109	0.2 mL strip tubes		each	6
110	0.2 ml PCR tubes		each	28
111	Barrier pipet tips 1000 uL		ul	5
112	Barrier pipet tips 200 uL		each	50
113	Barrier pipet tips 20uL		each	405
114	Milli-Q water		ml	35
115	Exonuclease I / Shrimp alkaline phosphatase		ul	4
116	Formamide	SL192	ul	30
117	Septa		each	0.3
118	Polymer		ul	1/125
119	Sequencing cassette		each	1
120	Running buffer		ul	80
121	15 mL centrifuge tubes	SL241		2
122	50 mL centrifuge tubes			2
123	2 mL plastic tubes		each	28
124	0.5 mL microcentrifuge tubes			34
125	Extraction tubs		each	4
126				
127	Equipment			Time in Use Minutes
128	Analytical balance		EP004	2
129	Capillary electrophoresis instrument, 96 well sequencing			72
130	Centrifuge		EP059	3
131	Cooling block			3
132	Gel electrophoresis apparatus with power supply		EP063	15
133	Gel imaging system		EP062	8
134	Micro-volume spectrophotometer with specimen retention technology			1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		81224	
	Meeting Date: April 2011		<i>CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)</i>	
2	<i>Adjusted for Batch Size - 10</i>			
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			29
6	<i>Lab Tech</i>	L033A		16
7	<i>Cytotechnologist</i>	L045A		13
8	TOTAL PRE-SERV CLINICAL LABOR TIME			20
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			9
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set Up	L045A	Cytotechnologist	2
17	PCR Gel	L045A	Cytotechnologist	2
18	PCR Post Processing	L045A	Cytotechnologist	3
19	Review sample and prepare data for interpretation	L045A	Cytotechnologist	2
20	Review sample			
21	Print/prepare results for medical director review			
22	End: When specimen is ready for examination by physician			
23	Service Period			
24				
25	Post-Service Period			
26	Start: When specimen examination by physician is complete			
27	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
28	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	1
29	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
30	Clean Room	L033A	Lab Tech	1
31	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
32	Perform scheduled data management back-up	L033A	Lab Tech	1
33	End: When specimen, chemical waste and record handling is complete			
34	SUPPLIES		Type of Unit	No. of Units
35	0.2 ml PCR tube		item	6
36	1.5ml tubes	SL240	item	2
37	Bleach	SL020	mL	1
38	Blood collection (6mL, purple top)	SL242	unit	1
39	DNA extraction instrument pipette tips		item	42
40	DNA extraction instrument reagent kit		reaction	1
41	gloves, non-sterile, nitrile	SB023	item	1
42	gown, staff, impervious	SB027	unit	0
43	High fidelity taq polymerase		µL	2
44	Labels		item	27
45	Microseal		item	1
46	Multichannel pipette tips		item	3
47	Multiplates		item	1
48	optical Ind Flat 8/cap strip		item	1
49	Paper		item	6
50	PCR and APSE WATER	SL251	µL	24
51	Pipette tips, 100ul		item	3
52	Pipette tips, 10ul		item	7
53	Pipette tips, 200ul		item	3
54	Pipette tips, 30ul		item	3
55	Synthetic Super Control		item	1

	A	B	C	D
56	xMAP Sheath Fluid		L	1
57	xTAG CF reagent kit		item	1
58				
59	Equipment			Time in Use Minutes
60	Centrifuge		EP059	3
61	Cooling block			9
62	Luminex instrument			3
63	Micro-volume spectrophotometer with specimen retention technology			1
64	Nucleic acid extraction instrument			5
65	Nucleic acid workstation			4
66	Pipet set		EP071	5
67	Sonicator bath			3
68	Thermal cycler			10
69	Water bath		EP043	10

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			81240	81241
2	Meeting Date: April 2011 <i>Adjusted for Batch Size - 8</i>			<i>F2 gene analysis; 20210G>A variant</i>	<i>F5 gene analysis; leiden variant</i>
3		CMS Code	Staff Type	Minutes	Minutes
4	Global Period			XXX	XXX
5	TOTAL CLINICAL LABOR TIME			32	32
6		<i>Lab Tech</i> L033A		16	16
7		<i>Cytotechnologist</i> L045A		16	16
8	TOTAL PRE-SERV CLINICAL LABOR TIME			23	23
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME				
10	TOTAL POST-SERV CLINICAL LABOR TIME			9	9
11	PRE-SERVICE				
12	Start: When preparing containers/requisitions for physician begins				
13	Confirm orders	L033A	Lab Tech	1	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6
15	Arrange consumables for extraction	L045A	Cytotechnologist	2	2
16	Load samples into sample cartridge	L045A	Cytotechnologist	1	1
17	Extraction on MagnaPure			0	0
18	Create master mix protocols and LightCycler worklists	L045A	Cytotechnologist	2	2
19	Prepare master mix in dead air box	L045A	Cytotechnologist	3	3
20	Transfer extracted DNA into tubes	L045A	Cytotechnologist	1	1
21	Set up LightCycler carousel	L045A	Cytotechnologist	2	2
22	Complete Helix extraction and master mix protocols in LIS	L045A	Cytotechnologist	1	1
23	Perform self-test on LightCycler and load files onto instrument	L045A	Cytotechnologist	1	1
24	Centrifuge carousel and load run	L045A	Cytotechnologist	1	1
25	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2	2
26	End: When specimen is ready for examination by physician				
27	Service Period				
28					
29	Post-Service Period				
30	Start: When specimen examination by physician is complete				
31	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2
32	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	1	1
33	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2
34	Clean Room	L033A	Lab Tech	1	1
35	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2
36	Perform scheduled data management back-up	L033A	Lab Tech	1	1
37	End: When specimen, chemical waste and record handling is complete				
38	SUPPLIES		Type of Unit	No. of Units	No. of Units
39	DNA isolation kit		reaction		1
40	Gown	SB027	item	0.25	0.25
41	Bleach 10%	SL020	ml	0.375	0.375
42	Extraction tip assembly		each	1	1
43	Extraction tubs		each	4	4
44	Barrier pipet tips 1000 uL		each	2	2
45	2 plastic tubes (1 1.5mL/1 2.0mL)		item	5	5
46	20 uL barrier pipe tips		item	4	4
47	200 uL barrier pipet tips		item	4	4
48	25mL serological pipettes		item	2	2
49	5mL serological pipettes		item	3	3
50	Bench paper		meter	0.1875	0.1875
51	Bouffant hats (pre and post)	SB001	item	0.25	0.25
52	DRF water	SL251	mL	3	3
53	drop catcher		item	1	1
54	gloves, nonsterile, nitrile	SB023	pairs	0.75	0.75
55	large reagent tubs/lids		item	2	2
56	LightCybler Factor II (Prothrombin) G20210A Kit		reactions	1	-
57	LightCycler Factor V Leiden Kit (30 reactions per kit)		reactions	-	1
58	medium reagent tubs/lids		item	4	4
59	Plastic bags (various sizes)		item	3	3
60	Plastic tubes		item	1	1
61	processing cartridges		item	2	2
62	Real-time PCR instrument capillaries		item	1	1
63	sample cartridges		item	3	3
64	Shoe covers (pre and post)	SB039	pairs	0.25	0.25
65	Tip stand		item	1	1
66	High fidelity hot start Taq polymerase		ul	0.375	0.375
67					
68	Equipment			Time in Use Minutes	Time in Use Minutes
69	Micro-volume spectrophotometer with specimen retention technology			1	1
70	Nucleic acid extraction instrument			5	5
71	Nucleic acid workstation			2	2
72	Pipet set		EP071	2	2
73	Real-time PCR instrument			6	6

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81243
	Meeting Date: April 2011			FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
2	<i>Adjusted for Batch Size - 8</i>			
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			45
6		<i>Lab Tech</i>	L033A	16
7		<i>Cytotechnologist</i>	L045A	29
8	TOTAL PRE-SERV CLINICAL LABOR TIME			36
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			9
11	PRE-SERVICE			
12	Confirm orders	L033A	Lab Tech	1
13	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
14	Retrieve and accession specimen: Receiving sample, checking for unacceptable conditions: clotted or frozen, serum, severely hemolyzed samples, green top heparin (contains preservative that interfer with PCR)			
15	Gather all prior reports and history on the patient: enter reason for testing, gender of patient, family history of fragile X or autism-spectrum disease, etc.			
16	Check blood tube against requisition			
17	Log in patient with accession ID, create patient list for testing			
18	Print out labels			
19	Setup extraction labels			
20	Extraction	L045A	Cytotechnologist	4
21	Gather all needed cartridges, internal control, and elution tubes, reagents and racks. Inspect cartridge integrity and fill volume in wells.			
22	Label and Load 1.5ml sample tube and elution tube for Compact MagNAPure Compact			
23	Load onto Compact, set up Compact run conditions, and run			
24	Check DNA concentration and 260/280 ratio on NanoDrop			
25	PCR	L045A	Cytotechnologist	6
26	Label Patient tubes (for dilution)			
27	Dilute DNA			
28	Prepare master mix			
29	Label 2 -8 tube strips			
30	Aliquot master mix			
31	Add diluted DNA			
32	Cap strips			
33	Place on PCR machine and start program			
34	PCR clean up			
35	PCR Gel	L045A	Cytotechnologist	6
36	Prepare Gel			
37	Mix samples with dye			
38	Load gel			
39	Gel picture			
40	Label picture			
41	PCR Injection, Detection onto Genetic Analyzer	L045A	Cytotechnologist	11
42	Label 2 -8 tube strips			
43	Dilute PCR			
44	Prepare master mix			
45	Prepare PCR plate: Aliquot PCR master mix into each PCR tube/well; Add patient sample into each PCR tube/cell			
46	Cap strips			
47	Place on PCR machine to denature + start program			
48	Place on ice			
49	Prepare plate map for injection with patient ID			
50	Setting up run module conditions and start run			
51	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
52	End: When specimen is ready for examination by physician			
53	Service Period			
54				
55	Post-Service Period			
56	Start: When specimen examination by physician is complete			
57	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
58	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	1
59	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
60	Clean Room	L033A	Lab Tech	1
61	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
62	Perform scheduled data management back-up	L033A	Lab Tech	1
63	End: When specimen, chemical waste and record handling is complete			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81243
	Meeting Date: April 2011			FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
2	<i>Adjusted for Batch Size - 8</i>			
3		CMS Code	Staff Type	Minutes
64	SUPPLIES		Type of Unit	No. of Units
65	DNA isolation		reaction	1
66	Bleach 10%	SL020	ml	0.375
67	Extraction tip assembly		each	1
68	Extraction tubs		each	4
69	High fidelity hot start Taq polymerase		ul	.0.375
70	Milli-Q water		ml	35
71	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
72	Masking tape		inches	12
73	0.5mL tubes		item	4.71
74	1.5 mL tubes	SL240	item	1.18
75	DNA LADDER,100 BP		uL	2.35
76	AGAROSE		g	1.76
77	ASR Primers for FMR1		mcl	0.94
78	ASR Primers for Gender		mcl	0.71
79	Blood collection (6mL, purple top)	SL242	unit	1.18
80	Buffer for genetic analyzer		mL	11.76
81	Capillary array		item	1.18
82	Cleanup Enzyme Mix		mcl	0.35
83	Coriell controls		mcl	29.41
84	Filtered, 1000mcl		item	1.18
85	Filtered, 10mcl		item	7.06
86	Filtered, 200mcl		item	7.06
87	Filtered, 20mcl		item	7.06
88	Formamide	SL192	mcl	1.00
89	gloves, non-sterile, nitrile	SB023	pair	0.50
90	gown, staff, impervious	SB027	item	0.38
91	High GC Buffer		mcl	4.71
92	Large volume compact		cartridge	
93	Map Marker		mcl	0.18
94	PCR 8 Tube Caps		item	2.35
95	PCR 8 Tube Strips, 0.2mL		item	2.35
96	Polymer for genetic analyzer		mcl	294.12
97	Strip caps		item	2.35
98	Strip tubes		item	2.35
99	SYBR Gel Stain		mcl	17.65
100	Triplet primed PCR enzyme mix		mcl	1.41
101				
102	Equipment			Time in Use Minutes
103	Analytical balance		EP004	1
104	Capillary electrophoresis instrument - fragment analysis			8
105	Centrifuge		EP059	1
106	Cooling block			1
107	Gel electrophoresis apparatus with power supply		EP063	4
108	Gel imaging system		EP062	1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81244
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 2</i>			FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			80
6	<i>Lab Tech</i>	L033A		18
7	<i>Cytotechnologist</i>	L045A		62
8	TOTAL PRE-SERV CLINICAL LABOR TIME			69
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Confirm orders	L033A	Lab Tech	1
13	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
14	Retrieve and accession specimen: Receiving sample, checking for unacceptable conditions: clotted or frozen, serum, severely hemolyzed samples, green top heparin (contains preservative that interfer with PCR)			
15	Gather all prior reports and history on the patient: enter reason for testing, gender of patient, family history of fragile X or autism-spectrum disease, etc.			
16	Check blood tube against requisition			
17	Log in patient with accession ID			
18	Print out labels			
19	Setup extraction labels			
20	EXTRACTION and Reaction	L045A	Cytotechnologist	4
21	Gather all needed cartridges, internal control, and elution tubes, reagents and racks. Inspect cartridge integrity and fill volume in wells.			
22	Label and Load 1.5ml sample tube and elution tube for Compact MagNAPure Compact			
23	Load onto Compact, set up Compact run conditions, and run			
24	Check DNA concentration and 260/280 ratio on NanoDrop			
25	Label patient tubes			
26	Dilute DNA			
27	Prepare restriction enzyme digestion reaction mix			
28	Aliquot restriction digestion reaction mix into each tube, add sample to the reaction mix			
29	Add diluted DNA			
30	Place in incubator			
31	Gel	L045A	Cytotechnologist	22
32	Prepare Gel			
33	Add Dye to samples			
34	Load gel			
35	Gel picture			
36	HCL			
37	NaCl/NaOH			
38	NaCl/Tris			
39	Prepare for blotting: Transfer DNA gel to Nytran membrane using turboblotter, wash membrane			
40	Blot the membrane dry and wrap in UV-transparent plastic wrap			
41	Post Processing 1: PreHyb+Hyb	L045A	Cytotechnologist	9
42	Prehyb			
43	Aliquot probe mix			
44	Put probe on ice			
45	Mix probe with hyb solution			
46	Add probe to blot + cap container			
47	Post Processing 2: Stringency washes	L045A	Cytotechnologist	5
48	Wash 1			
49	Wash 2			
50	Post Processing 3: Detection	L045A	Cytotechnologist	20
51	Wash 1			
52	Wash 2			
53	Prepare wash 3 (buffer + probe)			
54	Wash 3			
55	Wash 4			
56	Detection Buffer			
57	CPD			
58	Place film in cassette			
59	Expose Film			
60	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
61	End: When specimen is ready for examination by physician			
62	Post-Service Period			
63	Start: When specimen examination by physician is complete			
64	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
65	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
66	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
67	Clean Room	L033A	Lab Tech	2
68	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
69	Perform scheduled data management back-up	L033A	Lab Tech	1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81244
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 2</i>		FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)	
3		CMS Code	Staff Type	Minutes
70	End: When specimen, chemical waste and record handling is complete			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81244
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 2</i>			FMR1 (Fragile X mental retardation 1) (eg, fragile X mental retardation) gene analysis; characterization of alleles (eg, expanded size and methylation status)
3		CMS Code	Staff Type	Minutes
71	SUPPLIES		Type of Unit	No. of Units
72	DNA isolation		reaction	1
73	Bleach 10%	SL020	ml	0.75
74	Extraction tip assembly		each	1
75	Extraction tubs		each	4
76	Milli-Q water		ml	35
77	Masking tape		inches	12
78	1.5 mL tubes	SL240	tubes	5.88
79	AGAROSE		g	1.76
80	Anti-Dig Antibody		mclL	2.35
81	Blood collection (6mL, purple top)	SL242	unit	1.18
82	Blotting paper		sheet	1.18
83	Boric Acid		g	3.24
84	Bromophenol Blue		g	1.18
85	Chemiluminescent detection reagent		mL	1.18
86	Coriell controls		mclL	2.94
87	Dig Easy Hyb		mL	47.65
88	Digoxigenin Labeled Probe		mclL	11.76
89	DNA ladder, 100bp		mclL	23.53
90	Eag 1		mclL	0.12
91	EcoR1		mclL	0.59
92	EDTA		g	10.94
93	Ficoll		g	2.12
94	Film		film	1.18
95	Filtered, 1000mclL		tips	11.76
96	Filtered, 10mclL		tips	70.59
97	Filtered, 200mclL		tips	70.59
98	Filtered, 20mclL		tips	70.59
99	gloves, non-sterile	SB022	pair	1.00
100	gown, staff, impervious	SB027	item	0.75
101	HCL		mL	4.71
102	Large Volume Compact		cartrid	2.35
103	NaOH (Pellets), ACS	SL128	g	4.82
104	Nylon Membrane		sheet	1.18
105	Potassium Phosphate		g	0.48
106	Sheet protector		sheet	1.18
107	Sodium Chloride		g	142.99
108	Sodium Citrate	SL127	g	41.51
109	Sodium Dodecyl Sulfate		g	11.76
110	Sodium Phosphate		g	11.76
111	Spermidine		g	0.03
112	SYBR Gel Stain		mclL	17.65
113	Tris Base		g	20.60
114	Wash and Blocking Buffer Set		blot	1.18
115	Xylene Cyanol		g	1.18
116				
117	Equipment			Time in Use Minutes
118	37 degree incubator			600
119	Analytical balance		EP004	1
120	Gel electrophoresis apparatus with power supply		EP063	600
121	Gel imaging system		EP062	4
122	Micro-volume spectrophotometer with specimen retention technology			1
123	Nucleic acid extraction instrument			5

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81256
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 8</i>			<i>HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)</i>
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			28
6		<i>Lab Tech</i>	L033A	16
7		<i>Cytotechnologist</i>	L045A	12
8	TOTAL PRE-SERV CLINICAL LABOR TIME			19
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			9
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set Up	L045A	Cytotechnologist	6
17	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
18	End: When specimen is ready for examination by physician			
19	Service Period			
20				
21	Post-Service Period			
22	Start: When specimen examination by physician is complete			
23	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
24	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	1
25	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
26	Clean Room	L033A	Lab Tech	1
27	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
28	Perform scheduled data management back-up	L033A	Lab Tech	1
29	End: When specimen, chemical waste and record handling is complete			
30	SUPPLIES		Type of Unit	No. of Units
31	DNA isolation kit		reaction	1
32	Gown	SB027	item	0.125
33	Bleach 10%	SL020	ml	0.375
34	PCR Water	SL244	ul	2
35	LightCycler 480 Genotyping Master Kit		Kit	1
36	LightCycler 480 Multiwell Plate 96		plate	2
37	Primers and Probes		ul	1
38	50 mL centrifuge tubes			2
39	Barrier pipet tips1000 uL		ul	2
40	Extraction tip assembly		each	1
41	Extraction tubs		each	4
42	2 plastic tubes (1 1.5mL/1 2.0mL)		item	5
43	20 µL barrier pipe tips		item	4
44	200 µL barrier pipet tips		item	4
45	25mL serological pipettes		item	2
46	5mL serological pipettes		item	3
47	Bench paper		meter	0.2187
48	Bouffant hats (pre and post)	SB001	item	0.25
49	DRF water	SL251	mL	3
50	drop catcher		item	1
51	gloves, nonsterile, nitrile	SB023	pairs	0.75
52	large reagent tubs/lids		item	2
53	medium reagent tubs/lids		item	4
54	Plastic bags (various sizes)		item	3
55	Plastic tubes		item	1
56	processing cartridges		item	2
57	sample cartridges		item	3
58	Shoe covers (pre and post)	SB039	pairs	0.25
59	Tip stand		item	1
60	High fidelity hot start Taq polymerase		ul	0.375

	A	B	C	D
61	Nucleic acid extraction instrument			5
62	Nucleic acid workstation			2
63	Pipet set		EP071	2
64	Real-time PCR instrument			6

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81270
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 5</i>			JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis; V617F variant
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			37
6		<i>Lab Tech</i> L033A		18
7		<i>Cytotechnologist</i> L045A		19
8	TOTAL PRE-SERV CLINICAL LABOR TIME			26
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set Up	L045A	Cytotechnologist	13
17	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
18	End: When specimen is ready for examination by physician			
19	Service Period			
20				
21	Post-Service Period			
22	Start: When specimen examination by physician is complete			
23	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
24	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
25	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
26	Clean Room	L033A	Lab Tech	2
27	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
28	Perform scheduled data management back-up	L033A	Lab Tech	1
29	End: When specimen, chemical waste and record handling is complete			
30	SUPPLIES		Type of Unit	No. of Units
31	DNA isolation		reaction	1
32	Gown	SB027	item	0.4
33	Gloves, nonsterile	SB022	pair	1.2
34	Bleach 10%	SL020	ml	0.6
35	Extraction tip assembly		each	1
36	Extraction tubs		each	4
37	JAK2 MutaQuant™ Kit (24 reactions per kit in duplicate)		item	2
38	Lightcycler 96-well plates		item	1
39	LightCycler TaqMan Master Kit (480 reactions per kit)		item	2
40	PCR grade water	SL244	uL	2
41	V617F 25X probe mix		ul	0.8
42	V617F 50 copies standard		ul	10
43	V617F 500 copies standard		ul	10
44	V617F 5000 copies standard		ul	10
45	V617F 50000 copies standard		ul	10
46	V617F positive control		ul	10
47	WT 25X probe mix		ul	0.8
48	WT 50 copies standard		ul	10
49	WT 500 copies standard		ul	10
50	WT 5000 copies standard		ul	10
51	WT 50000 copies standard		ul	10
52	WT positive control		ul	10
53	15 mL centrifuge tubes	SL241		2
54	50 mL centrifuge tubes			2
55	Aerosol-resistant Pipette Tips, 0.1-20 ul		item	1
56	Aerosol-resistant Pipette Tips, 101-1000 ul		item	3
57	Aerosol-resistant Pipette Tips, 10-200 ul		item	12
58	Microcentrifuge Tubes, 0.5 ml		item	2
59	Barrier pipet tips 1000 uL		each	2
60	2 plastic tubes (1 1.5mL/1 2.0mL)		item	5
61	25mL serological pipettes		item	2
62	5mL serological pipettes		item	3
63	Bench paper		meter	1.5
64	Bouffant hats (pre and post)	SB001	item	0.4
65	DRF water	SL251	mL	3
66	drop catcher		item	1
67	large reagent tubs/lids		item	2

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81270
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 5</i>			JAK2 (Janus kinase 2) (eg, myeloproliferative disorder) gene analysis; V617F variant
3		CMS Code	Staff Type	Minutes
68	medium reagent tubs/lids		item	4
69	Plastic bags (various sizes)		item	3
70	processing cartridges		item	2
71	sample cartridges		item	3
72	Plastic tubes		item	1
73	Shoe covers (pre and post)	SB039	pairs	0.4
74	Tip stand		item	1
75	High fidelity hot start Taq polymerase		ul	0.375
76				
77	Equipment			Time in Use Minutes
78	Micro-volume spectrophotometer with specimen retention technology			1
79	Nucleic acid extraction instrument			5
80	Nucleic acid workstation			3
81	Pipet set		EP071	3
82	Real-time PCR instrument			9

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81275
	Meeting Date: April 2011 Specialty: Pathology			<i>KRAS gene analysis; variants in codons 12 and 13</i>
2	<i>Adjusted for Batch Size - 5</i>			
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			44
6		<i>Lab Tech</i> L033A	<i>Lab Tech</i>	18
7		<i>Cytotechnologist</i> L045A	<i>Cytotechnologist</i>	26
8	TOTAL PRE-SERV CLINICAL LABOR TIME			33
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	6
16	Cutting sections from specimen block using microtome			
17	Removal of paraffin			
18	DNA extraction			
19	Dilution of DNA extraction 1:5 or 1:10			
20	PCR Reaction	L045A	Cytotechnologist	18
21	Thaw the control reaction mix and mixed standard and mix			
22	Pipet mix control master mix			
23	Add mixed standard to tube A1, water tube A2, and sample to other tubes			
24	Close tubes and spin			
25	Place tubes into real-time PCR instrument			
26	Program instrument, enter run parameters, complete documentation			
27	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
28	End: When specimen is ready for examination by physician			
29	Service Period			
30				
31	Post-Service Period			
32	Start: When specimen examination by physician is complete			
33	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
34	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
35	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
36	Clean Room	L033A	Lab Tech	2
37	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
38	Perform scheduled data management back-up	L033A	Lab Tech	1
39	End: When specimen, chemical waste and record handling is complete			
40	SUPPLIES		Type of Unit	No. of Units
41	DNA isolation kit		kit	0.10
42	KRAS TheraScreen Mutation Kit		kit	0.25
43	Barrier pipet tips 20uL		each	8
44	100% ethanol	SL189	ml	50
45	8-well PCR tubes, clear, ultra thin		item	1
46	8-well StripCap, dome caps		item	1
47	95% Alcohol		ml	50
48	Biohazard bag with holder		item	1
49	Bleach, 10%	SL020	ml	4
50	Centrifuge tubes 15 mL	SL241	item	1
51	Centrifuge tubes 50 mL		item	1
52	DI water	SL244	ml	50
53	Ethanol, 70%	SL190	ml	10
54	EU thin wall plate 96 x 0.2 mL		item	1
55	EU wide optical 8-cap strip		item	1
56	Gauze, 4 x 4	SG051	item	1
57	Gloves, nonsterile, nitrile	SB023	item	2
58	gown, staff, impervious	SB027	item	1
59	Kimwipe	SM027	item	2
60	Micro tubes 2.0 mL		item	2
61	Micro tubes, 1.5 mL with caps		item	4
62	Microtube, 1.5 mL with locking lid		item	1
63	PCR Grade Water	SL244	ml	50
64	Pipette tips with aerosol barrier: 1000 µL		item	6
65	Pipette tips with aerosol barrier: 200 µL		item	6
66	Pipette tips with aerosol barrier: 100 µL		item	6
67	Pipette tips with aerosol barrier: 30 µL		item	6
68	Pipette tips with aerosol barrier: 10 uL		item	6
69	Xylene	SL151	ml	50

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81275
	Meeting Date: April 2011 Specialty: Pathology			<i>KRAS gene analysis; variants in codons 12 and 13</i>
2	<i>Adjusted for Batch Size - 5</i>			
3		CMS Code	Staff Type	Minutes
70	Extraction tip assembly		each	1
71	Extraction tubs		each	1
72				
73	Equipment			Time in Use Minutes
74	Micro-volume spectrophotometer with specimen retention technology			1
75	Nucleic acid extraction instrument			5
76	Nucleic acid workstation			3
77	Pipet set		EP071	3
78	Real-time PCR instrument			9
79	Solvent recycler system			2
80				

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81291
2	Meeting Date: April 2011 <i>Adjusted for Batch Size - 4</i>			<i>MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)</i>
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			64
6	<i>Lab Tech</i>	L033A		18
7	<i>Cytotechnologist</i>	L045A		46
8	TOTAL PRE-SERV CLINICAL LABOR TIME			53
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set Up	L045A	Cytotechnologist	10
17	PCR Gel	L045A	Cytotechnologist	10
18	PCR Post Processing	L045A	Cytotechnologist	20
19	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
20	End: When specimen is ready for examination by physician			
21	Service Period			
22				
23	Post-Service Period			
24	Start: When specimen examination by physician is complete			
25	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
26	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
27	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
28	Clean Room	L033A	Lab Tech	2
29	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
30	Perform scheduled data management back-up	L033A	Lab Tech	1
31	End: When specimen, chemical waste and record handling is complete			
32	SUPPLIES		Type of Unit	No. of Units
33	DNA isolation kit		reaction	1
34	Gown	SB027	item	0.5
35	Gloves, nonsterile	SB022	pair	2.5
36	Bleach 10%	SL020	ml	0.75
37	High fidelity hot start Taq polymerase		ul	0.5
38	PCR buffer		ul	15
39	MgCl ₂		ul	4.5
40	F Primer		ul	3
41	R Primer		ul	3
42	dNTPs		ul	3
43	Restriction Enzyme: HinfI, 25000 Units restriction enzyme		ul	3
44	Restriction Enzyme: MbolI, 1500 Units		ul	3
45	Agarose ultrapure		g	0.8
46	Agarose NuSieve GTG		g	1.6
47	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
48	0		ml	35
49	Masking tape		inches	12
50	DNA ladder, 100bp		ul	5
51	Loading buffer with dye	SL210	ul	20
52	BSA 100X		ul	3
53	PCR grade water	SL244	ul	102
54	0.2 mL PCR tubes		each	6
55	2 mL plastic tubes		each	2
56	Restriction enzyme buffer		ul	60
57	Milli-Q water		ml	35
58	Extraction tubs		each	4
59	15 mL centrifuge tubes	SL241		2
60	50 mL centrifuge tubes			2
61	Barrier pipet tips 200 uL		item	22
62	Barrier pipet tips 1000 uL		item	4
63	Barrier pipet tips 20 uL		item	55
64	0.5 mL tube		each	3
65	Extraction tip assembly		each	1
66				

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation			81291
2	Meeting Date: April 2011 <i>Adjusted for Batch Size - 4</i>			<i>MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)</i>
3		CMS Code	Staff Type	Minutes
67	Equipment			Time in Use Minutes
68	Analytical balance		EP004	1
69	Centrifuge		EP059	2
70	Cooling block			2
71	Gel electrophoresis apparatus with power supply		EP063	30

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			81315	81316
2	Meeting Date: April 2011 Typical Batch Size - 2			PML-RARA _{capna} , t(10,17); (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	PML-RARA _{capna} , t(10,17); (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative
3		CMS Code	Staff Type	Minutes	Minutes
4	Global Period			XXX	XXX
5	TOTAL CLINICAL LABOR TIME			93	93
6		Lab Tech	L033A	18	18
7		Cytotechnologist	L045A	75	75
8	TOTAL PRE-SERV CLINICAL LABOR TIME			82	82
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME				
10	TOTAL POST-SERV CLINICAL LABOR TIME			11	11
11	PRE-SERVICE				
12	Confirm orders	L033A	Lab Tech	1	1
13	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6	6
14	Clean counter top/new mat/obtain ice	L045A	Cytotechnologist	2	2
15	Label 5ml conical tube/pipette sample/ Add Buffer EL first wash	L045A	Cytotechnologist	2	2
16	Label kit tubes	L045A	Cytotechnologist	2	2
17	Remove supernatant/ Add Buffer EL second wash	L045A	Cytotechnologist	1	1
18	Remove supernatant/ place on ice/return to RNA bench	L045A	Cytotechnologist	2	2
19	Add RLT/BME/ pipette to mix/ pipette sample in QIAshredder	L045A	Cytotechnologist	1	1
20	Remove column/ Add ETOH to supernatant/ pipette to mix/Add half supernatant to QIAamp spin column	L045A	Cytotechnologist	1	1
21	Transfer QIAamp spin column to next collection tube/Add remainder of supernatant to column	L045A	Cytotechnologist	1	1
22	Transfer QIAamp spin column to next collection tube/Add RW1; Transfer QIAamp spin column to next collection tube/Add RPE; Transfer QIAamp spin column to next collection tube/Add RPE	L045A	Cytotechnologist	2	2
23	Transfer QIAamp column to 1.5 ml microcentrifuge tube/ Add Rnase-free water;Disgard QIAamp column/cap sample	L045A	Cytotechnologist	1	1
24	Initialize and blank nanodrop	L045A	Cytotechnologist	1	1
25	Quant sample/print	L045A	Cytotechnologist	1	1
26	Place sample in -70 freezer; Log quant information in RNA book	L045A	Cytotechnologist	1	1
27	Decontaminate environmental chambers and mark sheets (clean room and assembly area)	L045A	Cytotechnologist	1	1
28	Enter patient information onto cDNA and PCR worksheets; calculate assay set-up	L045A	Cytotechnologist	7	7
29	Clean counter top/new mat/obtain RNA free water from clean room; Obtain ice/controls and sample	L045A	Cytotechnologist	1	1
30	Label tubes/thaw samples/make sensitivity controls/pipette samples	L045A	Cytotechnologist	2	2
31	Heat RNA/obtain cDNA master mix reagents and thaw/make RT master mix	L045A	Cytotechnologist	2	2
32	Add RT master mix into samples/vortex	L045A	Cytotechnologist	3	3
33	Obtain PCR master mix reagents/go to clean room/label PCR tubes	L045A	Cytotechnologist	5	5
34	Thaw PCR master mix reagents/make master mixes for PMLRAR1, PMLRAR2, B2-microglobulin/vortex master mixes/quick centrifuge/aliquot into PCR strip tubes/cap/transfer to tamer 2	L045A	Cytotechnologist	5	5
35	Uncap PCR strip tubes/add samples to master mixes PMLRAR1, PMLRAR2, B2-microglobulin/cap samples	L045A	Cytotechnologist	2	2
36	Vortex PCR strip tubes/quick centrifuge/place samples in thermocycler	L045A	Cytotechnologist	1	1
37	Obtain samples from thermocycler/quick vortex/quick centrifuge/transfer to dark room	L045A	Cytotechnologist	1	1
38	Remove caps/load 6 ul loading dye to each PCR well leaving tip	L045A	Cytotechnologist	1	1
39	Fill bucket with water and place on hot plate	L045A	Cytotechnologist	1	1
40	Measure agarose on balance	L045A	Cytotechnologist	1	1
41	Add Tris to flask; Stir in agarose to boiling Tris	L045A	Cytotechnologist	1	1
42	Cool gel to room temperature and pour into gel apparatus	L045A	Cytotechnologist	1	1
43	Remove gel combs	L045A	Cytotechnologist	1	1
44	Add buffer	L045A	Cytotechnologist	1	1
45	Add loading dye to PCR strips	L045A	Cytotechnologist	2	2
46	Load DNA allelic ladder and PMLRAR1, PMLRAR2, and B2-microglobulin samples into gel/close gel box; Record sample location of all samples	L045A	Cytotechnologist	2	2
47	Obtain cords/hook up to electrophoresis power supply/set voltage and timer; Turn off power supply and unconnect power leads	L045A	Cytotechnologist	1	1
48	GEL	L045A	Cytotechnologist	13	13
49	Remove gels and place in tray				
50	Add stain (ethidium bromide); shake				
51	Remove ethidium bromide				
52	Place gel onto UV Transilluminator to check for band quality before analysis				
53	Place gels in buffer				
54	Turn on gel doc and open software; place gel into gel doc				
55	Capture image				
56	Label image with patient names, control information and primer sets				
57	Print image				
58	Clean gel doc				
59	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2	2
60	End: When specimen is ready for examination by physician				
61	Service Period				
62					

	A	B	C	D	E
1	AMA Specialty Society RVS Update Committee Recommendation			81315	81316
2	Meeting Date: April 2011 Typical Batch Size - 2			PML/RARa t(15;17); (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	PML/RARa t(15;17); (PML-RARA regulated adaptor molecule 1) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative
63	Post-Service Period				
64	Start: When specimen examination by physician is complete				
65	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2	2
66	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2	2
67	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2	2
68	Clean Room	L033A	Lab Tech	2	2
69	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2	2
70	Perform scheduled data management back-up	L033A	Lab Tech	1	1
71	End: When specimen, chemical waste and record handling is complete				
72	SUPPLIES		Type of Unit	No. of Units	No. of Units
73	RNA isolation kit		Kit	0.04	0.04
74	PAXgene RNA tube		Kit	0.02	0.02
75	Gown	SB027	item	2	2
76	Gloves		pair	10	10
77	Bleach 10%	SL020	ml	30	30
78	PML-1 + RAR-1 primers - Intron 3 primers reconstituted in RNase free water		ul	12	12
79	0.1ng/ul PML-1/RAR-1 Intron 3+ control		ul	1	1
80	1.5 microcentrifuge tube		item	1	1
81	1.5 ml microcentrifuge tubes		item	7	7
82	10 ml Serological pipette		item	1	1
83	10X TBE		ml	300	300
84	15 mL conical Tube		item	1	1
85	2 ml collection tube		item	4	4
86	3:1 agarose		grams	6.75	6.75
87	5 ml Serological pipette		item	2	2
88	50-1000 bp DNA marker		ul	60	60
89	8-strip 0.2 ml thin wall tubes		item	3	3
90	8-strip caps for 0.2 ml thin wall tubes		item	3	3
91	Aerosol resistant pipette tips – 0.2 - 10 ul		item	32	32
92	Aerosol resistant pipette tips – 1 - 1000 ul		item	7	7
93	Aerosol resistant pipette tips – 1 - 20 ul		item	28	28
94	Aerosol resistant pipette tips – 1 - 200 ul		item	40	40
95	Bench top mat		item	2	2
96	Beta 2 microglobulin primers reconstituted in RNase free water		item	12	12
97	Biopolymer homogenizing kit		item	1	1
98	Deoxynucleotide Triphosphate Set, PCR Grade		ul	15	15
99	dNTP Mix, 5 mM each		ul	26	26
100	Face Shield		item	1	1
101	Glass Pasteur pipets		item	2	2
102	High fidelity hot start taq polymerase		ul	1.8	1.8
103	Human Universal Reference Total RNA control		ul	30	30
104	Labels for tubes		item	7	7
105	MgCl2		ul	18	18
106	Papertowels		item	6	6
107	PML/RARa t(15;17) L-form RNA IVS-0020 control		ul	2	2
108	PML-2 + RAR-2 primers - Intron 6 primers reconstituted in RNase free water		ul	12	12
109	Random Primers		ul	7	7
110	Reverse transcriptase		ul	7	7
111	Reverse transcriptase buffer, 10X		ul	14	14
112	RNA extraction kit		item	0	0
113	RNase free water		ul	20	20
114	RNase-free water		ul	642	642
115	RNase-Inhibitor		ul	5.25	5.25
116	TE (Tris EDTA) Buffer 10:1 - 100X concentrate		ml	3000	3000
117	Test tube - purple top		item	1	1
118	Thin walled PCR tubes with caps		item	6	6
119	Equipment			Time in Use Minutes	Time in Use Minutes
120	Analytical balance		EP004	1	1
121	Centrifuge		EP059	3	3
122	Cooling block			3	3
123	Gel electrophoresis apparatus with power supply		EP063	30	30
124	Gel imaging system		EP062	4	4
125	Micro-volume spectrophotometer with specimen retention technology			1	1
126	Nucleic acid extraction instrument			9	9
127	Nucleic acid workstation			15	15
128	Pipet set		EP071	20	20
129	Thermal cycler			50	50
130	Water bath		EP043	10	10

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2011

Molecular Pathology-Tier 2

The CPT Editorial Panel has developed a new coding structure to describe molecular pathology services, based on the efforts and recommendations of the Molecular Pathology Coding Workgroup convened beginning in October 2009. In October 2010, the Panel accepted 9 Tier 2 codes, which are a list of codes to be reported when the service is not listed in the Tier 1 codes. The Tier 2 codes are arranged by the level of technical resources and interpretive professional work required. The RUC understands that these services will be rarely reported and represent tests that are largely under development and unlikely to be automated at this time. Once a test has matured, utilization increases, and efficiencies are created, the RUC understands that the test will be assigned a Tier 1 code. These services were previously reported with a series of “stacking codes.” The RUC understands that payment for these services is currently based on a mixture of payment methodologies, including the physician fee schedule and the clinical lab fee schedule. CMS has requested that the RUC review data provided by the College of American Pathologists to provide the agency with more information as a policy is developed to determine which payment schedule is appropriate for these services.

Overall, the RUC found it difficult to appropriately assign a work valuation to these services. The number of survey respondents for each code ranged from 11 to 26, all below the RUC’s required minimum of thirty respondents. The recommendations submitted by the specialty did not reflect appropriate valuation given the corresponding time recommendations. **The RUC proposes the following recommendations as interim. The specialty will re-survey these codes in Summer 2011 and present new data at the September 2011 RUC meeting.**

81400 Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)

The RUC reviewed the median survey time of 10 minutes and recommends the median survey work RVU of 0.37. The RUC agreed that this placed the service in appropriate rank order with a 99212 *Office Visit, Level II* (total time =16 minutes; work RVU = 0.48). For further support, the RUC also determined that this service is similar to 80500 *Clinical pathology consultation; limited, without review of patient's history and medical records* (total time = 13 minutes, work RVU = 0.37). **The RUC recommends an interim work RVU of 0.37 for CPT code 81400.**

81401 Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)

The RUC reviewed the median survey time of 13 minutes and recommends the median survey work RVU of 0.55. The RUC agreed that this placed the service in appropriate rank order with a 99212 *Office Visit, Level II* (total time =16 minutes; work RVU = 0.48). For further support, the RUC referenced similar service 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (total time = 20 minutes, work RVU = 0.62). **The RUC recommends an interim work RVU of 0.55 for CPT code 81401.**

81402 Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)

The RUC reviewed the median survey time of 18 minutes and recommends the median survey work RVU of 0.68. The RUC agreed that this placed the service in appropriate rank order with a 99212 *Office Visit, Level II* (total time = 16 minutes; work RVU = 0.48). For further support the RUC referenced similar service 88387 *Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a single lymph node)* (total time = 20 minutes, work RVU = 0.62). **The RUC recommends an interim work RVU of 0.68 for CPT code 81402.**

81403 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)

The RUC reviewed the median survey time of 30 minutes and recommends the median survey work RVU of 0.85. The RUC agreed that this placed the service in appropriate rank order with a 99213 *Office Visit, Level II* (total time = 23 minutes; work RVU = 0.97). For further support the RUC referenced similar service 88342 *Immunohistochemistry (including tissue immunoperoxidase), each antibody* (total time = 27 minutes, work RVU = 0.85). **The RUC recommends an interim work RVU of 0.85 for CPT code 81403.**

81404 Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

The RUC reviewed the median survey time of 45 minutes and recommends the median 75th percentile work RVU of 1.30. The RUC agreed that this placed the service in appropriate rank order with a 99214 *Office Visit, Level II* (total time = 40 minutes; work RVU = 1.50). For further support the RUC referenced similar service 80502 *Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records* (total time = 42 minutes, work RVU = 1.33). **The RUC recommends an interim work RVU of 1.30 for CPT code 81404.**

81405 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)

The RUC reviewed the median survey time of 45 minutes and recommends the median 75th percentile value of 1.33. The RUC agreed that this placed the service in appropriate rank order with a 99214 *Office Visit, Level II* (total time = 40 minutes; work RVU = 1.50). For further support the RUC referenced similar service 80502 *Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records* (total time = 42 minutes, work RVU = 1.33). **The RUC recommends an interim work RVU of 1.33 for CPT code 81405.**

81406 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)

The RUC reviewed the median survey time of 60 minutes and recommends the median 75th percentile work RVU of 1.55. The RUC agreed that this placed the service in appropriate rank order with a 99214 *Office Visit, Level II* (total time = 40 minutes; work RVU = 1.50). For further support the RUC referenced similar service 88307 *Level V Surgical pathology, gross and microscopic examination* (total time = 47 minutes, work RVU = 1.59). **The RUC recommends an interim work RVU of 1.55 for CPT code 81406.**

81407 Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)

The RUC reviewed the median survey time of 63 minutes. The RUC agreed that the service should be directly crosswalked to 88307 *Level V Surgical pathology, gross and microscopic examination* (total time = 47 minutes, work RVU = 1.59). The RUC agreed that this placed the service in appropriate rank order with a 99214 *Office Visit, Level II* (total time = 40 minutes; work RVU = 1.50). **The RUC recommends an interim work RVU of 1.59 for CPT code 81407.**

81408 Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)

The RUC reviewed the median survey time of 73 minutes and recommends the median 75th percentile work RVU of 1.75. The RUC agreed that this placed the service in appropriate rank order with a 99214 *Office Visit, Level II* (total time = 40 minutes; work RVU = 1.50) and 88307 *Level V Surgical pathology, gross and microscopic examination* (total time = 47 minutes, work RVU = 1.59). Additionally, the RUC agreed that the surveyed service requires more physician work to perform compared to 88188 *Flow cytometry, interpretation; 9 to 15 markers* (total time = 43 minutes, work RVU = 1.69). **The RUC recommends an interim work RVU of 1.75 for 81404.**

Practice Expense

The specialty provided data based on assumed batch sizes and modified these batch size estimates to ensure maximum efficiency for today's practice. However, these assumptions should be re-examined when greater experience is available for these services.

Work Neutrality

Reviewing the Medicare utilization data for 83912 *Molecular diagnostics; interpretation and report* (work RVU = 0.37) and the specialty's estimate of utilization of these individual services, the RUC understands that these recommendations will be work neutral to the family.

New Technology

The entire set of molecular pathology codes should be re-reviewed after claims data are available and there is experience with the new coding system. The time, work valuation, and practice expense inputs should all be reviewed again in the future as these estimates are based on a good faith effort using available information in 2011.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
83912		Molecular diagnostics; interpretation and report	XXX	0.37 (No Change)
<p>Pathology and Laboratory <u>Molecular Pathology</u></p> <p><u>The following Molecular Pathology Procedure (Tier 2) codes are used to report procedures not listed in the Tier 1 molecular pathology codes (AXXX1-UXXX1). They represent medically useful procedures that are generally performed in lower volumes than Tier 1 procedures (eg, the incidence of the disease being tested is rare). They are arranged by level of technical resources and interpretive work by the physician or other qualified health care professional. The individual analyses listed under each code (ie, level of procedure) utilize the definitions and coding principles as described in the introduction preceding the Tier 1 molecular pathology codes. The parenthetical examples of methodologies presented near the beginning of each code provide general guidelines used to group procedures for a given level and are not all-inclusive.</u></p> <p><u>Use the appropriate molecular pathology procedure level code that includes the specific analyte listed after the code descriptor. If the analyte tested is not listed under one of the Tier 2 codes or is not represented by a Tier 1 code, use the appropriate methodology codes in the 83890-83914 and 88384-88386 series.</u></p>				
● 81400	AA1	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis) ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), K304E variant ACE (angiotensin converting enzyme) (eg, hereditary blood pressure regulation), insertion/deletion variant AGTR1 (angiotensin II receptor, type 1) (eg, essential hypertension), 1166A>C variant CCR5 (chemokine C-C motif receptor 5) (eg, HIV resistance), 32-bp deletion	XXX	0.37 (Interim)

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>mutation/794 825del32 deletion</p> <p>DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), IVS14+1G>A variant</p> <p>F2 (coagulation factor 2) (eg, hereditary hypercoagulability), 1199G>A variant</p> <p>F5 (coagulation factor V) (eg, hereditary hypercoagulability), HR2 variant</p> <p>F7 (coagulation factor VII [serum prothrombin conversion accelerator]) (eg, hereditary hypercoagulability), R353Q variant</p> <p>FGB (fibrinogen beta chain) (eg, hereditary ischemic heart disease), -455G>A variant</p> <p>F13B (coagulation factor XIII, B polypeptide) (eg, hereditary hypercoagulability), V34L variant</p> <p>SERPINE1 (serpine peptidase inhibitor clade E, member 1, plasminogen activator inhibitor -1, PAI-1) (eg, thrombophilia), 4G variant</p>		
● 81401	AA2	<p>Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)</p> <p>ABL (c-abl oncogene 1, receptor tyrosine kinase) (eg, acquired imatinib resistance), common <u>T315I</u> variant (ie, T315I)</p> <p>ACADM (acyl-CoA dehydrogenase, C-4 to C-12 straight chain, MCAD) (eg, medium chain acyl dehydrogenase deficiency), commons variants (eg, K304E,</p>	XXX	0.55 (Interim)

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>Y42H)</p> <p>ADRB2 (adrenergic beta-2 receptor surface) (eg, drug metabolism), common variants (eg, G16R, Q27E)</p> <p>APOE (apolipoprotein E) (eg, hyperlipoproteinemia type III, cardiovascular disease, Alzheimer disease), common variants (eg, *2, *3, *4)</p> <p>CBFB/MYH11 (inv(16)) (eg, acute myeloid leukemia), qualitative, and quantitative, if performed</p> <p>CCND1/IgH (BCL1/IgH, t(11;14)(d)) (eg, mantle cell lymphoma) translocation analysis, major breakpoint, qualitative, and quantitative if performed</p> <p>CYP3A4 (cytochrome P450, family 3, subfamily A, polypeptide 4) (eg, drug metabolism), common variants (eg, *2, *3, *4, *5, *6)</p> <p>CYP3A5 (cytochrome P450, family 3, subfamily A, polypeptide 5) (eg, drug metabolism), common variants (eg, *2, *3, *4, *5, *6)</p> <p>CFH/ARMS2 (complement factor H/age-related maculopathy susceptibility 2) (eg, macular degeneration), common variants (eg, Y402H [CFH], A69S [ARMS2])</p> <p>DMPK (dystrophia myotonica-protein kinase) (eg, myotonic dystrophy, type 1), evaluation to detect abnormal (eg, expanded) alleles</p> <p>F11 (coagulation factor XI) (eg, coagulation disorder), common variants (eg, E117X [Type II], F283L [Type III], IVS14del14, and IVS14+1G>A [Type I])</p> <p>FGFR3 (fibroblast growth factor receptor 3) (eg, achondroplasia), common variants (eg, 1138G>A, 1138G>C)</p>		

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>FIP1L1/PDGFR (del[4q12]) (eg, imatinib-sensitive chronic eosinophilic leukemia), qualitative, and quantitative, if performed</p> <p>GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), common variants (eg, Q188R, S135L, K285N, T138M, L195P, Y209C, IVS2-2A>G, P171S, del5kb, N314D, L218L/N314D)</p> <p>HBB (hemoglobin, beta) (eg, sickle cell anemia, hemoglobin C, hemoglobin E), common variants (eg, HbS, HbC, HbE)</p> <p>HTT (huntingtin) (eg, Huntington disease), evaluation to detect abnormal (eg, expanded) alleles</p> <p>RUNX1/RUNX1T1 (t[8;21]) (eg, acute myeloid leukemia) translocation analysis, qualitative, and quantitative, if performed</p> <p>TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), common variants (eg, *2, *3)</p> <p>VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), common variants (eg, T791M, R816W, R854Q)</p>		
● 81402	AA3	<p>Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)</p> <p>CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide 2) (eg, congenital adrenal hyperplasia, 21-hydroxylase deficiency), common variants (eg, IVS2-13G, P30L, I172N, exon 6 mutation cluster [I235N, V236E, M238K], V281L, L307FfsX6, Q318X, R356W, P453S, G110VfsX21, 30-kb deletion variant)</p>	XXX	0.68 (Interim)

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, mastocytosis), common variants (eg, D816V, D816Y, D816F)</p> <p>MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants (eg, E148Q, P369S, F479L, M680I, I692del, M694V, M694I, K695R, V726A, A744S, R761H)</p> <p>TCD@ (T cell antigen receptor, delta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population</p>		
●81403	AA4	<p>Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)</p> <p>ABL1 (c-abl oncogene 1, receptor tyrosine kinase) (eg, acquired imatinib tyrosine kinase inhibitor resistance), variants in the kinase domain</p> <p>DAZ/SRY (deleted in azoospermia and sex determining region Y) (eg, male infertility), common deletions (eg, AZFa, AZFb, AZFc, AZFd)</p> <p>JAK2 (Janus kinase 2) (eg, myeloproliferative disorder), exon 12 sequence and exon 13 sequence, if performed</p> <p>MPL (myeloproliferative leukemia virus oncogene, thrombopoietin receptor, TPOR) (eg, myeloproliferative disorder), exon 10 sequence</p> <p>VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), deletion/duplication analysis</p> <p>VWF (von Willebrand factor) (eg, von Willebrand disease types 2A, 2B, 2M),</p>	XXX	0.85 (Interim)

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		targeted sequence analysis (eg, exon 28)		
● 81404	AA5	<p>Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)</p> <p>BTD (biotinidase) (eg, biotinidase deficiency), full gene sequence</p> <p>CYP1B1 (cytochrome P450, family 1, subfamily B, polypeptide 1) (eg, primary congenital glaucoma), full gene sequence</p> <p>DMPK (dystrophia myotonica-protein kinase) (eg, myotonic dystrophy type 1), characterization of abnormal (eg, expanded) alleles</p> <p>FKRP (Fukutin related protein) (eg, congenital muscular dystrophy type 1C [MDC1C], limb-girdle muscular dystrophy [LGMD] type 2I), full gene sequence</p> <p>FOXP1 (forkhead box G1) (eg, Rett syndrome), full gene sequence</p> <p>FSHMD1A (facioscapulohumeral muscular dystrophy 1A) (eg, facioscapulohumeral muscular dystrophy), evaluation to detect abnormal (eg, deleted) alleles</p> <p>HBB (hemoglobin, beta, Beta-Globin) (eg, thalassemia), full gene sequence</p> <p>KIT (C-kit) (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (eg, GIST, acute myeloid leukemia, melanoma), targeted gene analysis (eg, exons 8, 11, 13, 17, 18)</p>	XXX	<p>1.30</p> <p>(Interim)</p>

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>MEFV (Mediterranean fever) (eg, familial Mediterranean fever), full gene sequence</p> <p>NRAS (neuroblastoma RAS viral oncogene homolog) (eg, colorectal carcinoma), exon 1 and exon 2 sequences</p> <p>PDGFRA (platelet-derived growth factor receptor alpha polypeptide) (eg, gastrointestinal stromal tumor), targeted sequence analysis (eg, exons 12, 18)</p> <p>RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2B and familial medullary thyroid carcinoma), common variants (eg, M918T, 2647_2648delinsTT, A883F)</p> <p>SDHD (succinate dehydrogenase complex, subunit D, integral membrane protein) (eg, hereditary paraganglioma), full gene sequence</p> <p>VHL (von Hippel-Lindau tumor suppressor) (eg, von Hippel-Lindau familial cancer syndrome), full gene sequence</p> <p>VWF (von Willebrand factor) (eg, von Willebrand disease type 1C), targeted sequence analysis (eg, exons 26, 27, 37)</p>		
● 81405	AA6	<p>Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)</p> <p>CYP21A2 (cytochrome P450, family 21, subfamily A, polypeptide2) (eg, steroid 21-hydroxylase isoform, congenital adrenal hyperplasia), full gene sequence</p> <p>FKTN (Fukutin) (eg, limb-girdle muscular dystrophy [LGMD] type 2M or 2L), full gene sequence</p>	XXX	<p>1.33</p> <p>(Interim)</p>

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
		<p>RET (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2A and familial medullary thyroid carcinoma), targeted sequence analysis (eg, exons 10, 11, 13-16)</p> <p>SDHB (succinate dehydrogenase complex, subunit B, iron sulfur) (eg, hereditary paraganglioma), full gene sequence</p> <p>TGFBR1 (transforming growth factor, beta receptor 1) (eg, Marfan syndrome), full gene sequence</p> <p>TGFBR2 (transforming growth factor, beta receptor 2) (eg, Marfan syndrome), full gene sequence</p> <p>THRB (thyroid hormone receptor, beta) (eg, thyroid hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of >5 exons</p> <p>TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome, tumor samples), full gene sequence or targeted sequence analysis of >5 exons</p> <p>VWF (von Willebrand factor) (eg, von Willebrand disease type 2N), targeted sequence analysis (eg, exons 18-20, 23-25)</p>		

● 81406	AA7	<p>Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)</p> <p>CAPN3 (Calpain 3) (eg, limb-girdle muscular dystrophy [LGMD] type 2A, alpainopathy), full gene sequence</p> <p>GALT (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), full gene sequence</p> <p>HEXA (hexosaminidase A, alpha polypeptide) (eg, Tay-Sachs disease), full gene sequence</p> <p>LMNA (lamin A/C) (eg, Emery-Dreifuss muscular dystrophy [EDMD1, 2 and 3] limb-girdle muscular dystrophy [LGMD] type 1B, dilated cardiomyopathy [CMD1A], familial partial lipodystrophy [FPLD2]), full gene sequence</p> <p>PAH (phenylalanine <u>phenylalanine</u> hydroxylase) (eg phenylketonuria), full gene sequence</p> <p>POMGNT1 (protein O-linked mannose beta1,2-N acetylglucosaminyltransferase) (eg, Muscle-Eye-Brain disease, Walker-Warburg syndrome), full gene sequence</p> <p>POMT1 (protein-O-mannosyltransferase 1) (eg, limb-girdle muscular dystrophy [LGMD] type 2K, Walker-Warburg syndrome), full gene sequence</p> <p>POMT2 (protein-O-mannosyltransferase 2) (eg, limb-girdle muscular dystrophy [LGMD] type 2N, Walker-Warburg syndrome), full gene sequence</p> <p>RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), targeted sequence analysis of exons with functionally-confirmed mutations</p> <p>VWF (von Willebrand factor) (von Willebrand disease type 2A), extended targeted sequence analysis (eg, exons 11-16, 24-26, 51, 52)</p>	XXX	1.55 (Interim)
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● 81407	AA8	<p>Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)</p> <p>SCN1A (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy, epilepsy with febrile seizures), full gene sequence</p>	XXX	1.59 (Interim)
● 81408	AA9	<p>Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)</p> <p>FBN1 (fibrillin 1) (eg, Marfan syndrome), full gene sequence</p> <p>NF1 (neurofibromin 1) (eg, neurofibromatosis, type 1), full gene sequence</p> <p>RYR1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), full gene sequence</p> <p>VFW (Von Willebrand factor) (Eg, malignant hypertermia), full gene sequence</p>	XXX	1.75 (Interim)



February 25, 2011

Barbara Levy, MD
Chair, RVS Update Committee
American Medical Association
515 N. State St.
Chicago, IL 60654

Re: New Molecular Pathology CPT Codes

Dear Dr. Levy:

The College of American Pathologists (CAP) supports physician fee schedule placement of the 28 Tier 1 molecular pathology codes approved at the October 2010 CPT Meeting, and the 9 Tier 2 codes approved at the February 2011 CPT meeting, as they all have a professional interpretive component. However, the Centers for Medicare and Medicaid Services (CMS) and the AMA/Specialty Society Relative Value Scale Update Committee (RUC) have specifically requested that the CAP bring forward at this time only proposed values for April 2011 RUC review that typically include physician interpretation.

The 28 Tier 1 codes and 9 Tier 2 codes identified in CAP's plan for review at the April RUC have been reviewed by a subgroup of CAP molecular pathologists together with our RBRVS workgroup. Of these 37 codes, 10 were determined to have their interpretation typically performed by a PhD at this time. These services are currently not typically performed in typical molecular pathology laboratories, but rather in subspecialty laboratories.

Therefore, in response to CMS' and the RUC's direct request, only the following codes will be presented at the April RUC meeting, because the interpretation of these codes is typically performed by a physician. In addition, the CAP reviewed the recently approved CPT codes from the February CPT meeting and determined which codes are typically interpreted by physicians.

As you know, at the February meeting, the RUC approved a plan outlining how CAP proposes to move forward in developing recommended values and direct practice expense inputs for the molecular pathology codes approved by the CPT Editorial Panel at its October 2010 and February 2011 meetings. This plan is to survey for April 2011 the 28 Tier 1 molecular codes and the 9 Tier 2 codes approved by CPT in February. Because of the RUC directive, 27 codes will be surveyed for the April RUC meeting. The remaining molecular codes approved at the February CPT meeting and identified as typically including physician work will be surveyed for the September 2011 RUC meeting.

Below please find the codes to be surveyed for the April 2011 RUC meeting, codes to be surveyed for the September 2011 RUC meeting, and codes not scheduled to be surveyed at this time.

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Codes to be Surveyed for April 2011 RUC Meeting

Tier 1

- BXXX2 *BCR/ABL1 (t[9;22])* (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative
- BXXX3 minor breakpoint, qualitative or quantitative
- BXXX4 other breakpoint, qualitative or quantitative
- CXXX1 *CFTR (cystic fibrosis transmembrane conductance regulator)* (eg, cystic fibrosis) gene analysis; common variants (eg, ACMG/ACOG guidelines)
- CXXX2 known familial variants
- CXXX3 duplication/deletion variants
- CXXX4 full gene sequence
- CXXX5 intron 8 poly-T analysis (eg, male infertility)
- FXXX1 *F2 (prothrombin, coagulation factor II)* (eg, hereditary hypercoagulability) gene analysis; 20210G>A variant
- FXXX2 *F5 (coagulation Factor V)* (eg, hereditary hypercoagulability) gene analysis; Leiden variant
- FXXX4 *FMR1 (Fragile X mental retardation 1)* (eg, fragile X mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
- FXXX5 characterization of alleles (eg, expanded size and methylation status)
- HXXX2 *HFE (hemochromatosis)* (eg, hereditary hemochromatosis) gene analysis; common variants (eg, C282Y, H63D)
- JXXX1 *JAK2 (Janus kinase 2)* (eg, myeloproliferative disorder) gene analysis; V617F variant
- KXXX1 *KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene)* (eg, carcinoma) gene analysis; variants in codons 12 and 13
- MXXX2 *MTHFR (5,10-methylenetetrahydrofolate reductase)* (eg, hereditary hypercoagulability) gene analysis; common variants (eg, 677T, 1298C)
- PXXX1 *PML/RARalpha, (t(15;17)), (PML-RARA regulated adaptor molecule 1)* (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative
- PXXX2 single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative

Tier 2

- L2XX1 Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)
- L2XX2 Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)

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- L2XX3 Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)
- L2XX4 Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)
- L2XX5 Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)
- L2XX6 Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)
- L2XX7 Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)
- L2XX8 Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)
- L2XX9 Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)

Codes to be Surveyed for September 2011 RUC Meeting

Tier 1

- BXXX6 *BRAF (v-raf murine sarcoma viral oncogene homolog B1)* (eg, colon cancer), gene analysis, V600E variant
- CXXX6 *CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)
- CXXX7 *CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)
- CXXX8 *CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9)* (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)
- CXXX9 *VKORC1 (vitamin K epoxide reductase complex, subunit 1)* (eg, warfarin metabolism), gene analysis, common variants (eg, 1639/3673)
- FXXX6 *FLT3 (fms-related tyrosine kinase 3)* (eg, acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (ie, exons 14, 15)
- HXXX3 *HBA1/HBA2 (alpha globin 1 and alpha globin 2)* (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis, for common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, and Constant Spring)

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- IXXX2 *IGH@ (Immunoglobulin heavy chain locus)* (eg, leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplification methodology (eg, polymerase chain reaction)
- IXXX3 direct probe methodology (eg, Southern blot)
- IXXX4 *IGH@ (Immunoglobulin heavy chain locus)* (eg, leukemia and lymphoma, B-cell), variable region somatic mutation analysis
- IXXX5 *IGK@ (Immunoglobulin kappa light chain locus)* (eg, leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
- IXXX6 Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)
- +● IXXX7 each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition to code for primary procedure)
- IXXX8 Chimerism (engraftment) analysis, post hematopoietic stem cell transplantation specimen, includes comparison to previously performed baseline analyses; without cell selection
- IXXX9 with cell selection (eg, CD3, CD33), each cell type
- MXXX3 *MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2)* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
- MXXX4 known familial variants
- MXXX5 duplication/deletion variants
- MXXX6 *MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1)* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
- MXXX7 known familial variants
- MXXX8 duplication/deletion variants
- MXXX9 *MSH6 (mutS homolog 6 [E. coli])* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
- MXX10 known familial variants
- MXX11 duplication/deletion variants

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- MXX12 Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (eg, BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed
- MXX13 *MECP2 (methyl CpG binding protein 2)* (eg, Rett syndrome) gene analysis; full sequence analysis
- MXX14 known familial variant
- MXX15 duplication/deletion variants
- NXXX3 *NPM1 (nucleophosmin)* (eg, acute myeloid leukemia) gene analysis, exon 12 variants
- PXXX3 *PMS2 (postmeiotic segregation increased 2 [S. cerevisiae])* (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
- PXXX4 known familial variants
- PXXX5 duplication/deletion variants
- SXXX2 *SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A)* (eg, Prader-Willi syndrome and/or Angelman syndrome), methylation analysis
- SXXX3 *SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1)* (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z)
- TXXX1 *TCB@ (T cell antigen receptor, beta)* (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)
- TXXX2 using direct probe methodology (eg, Southern blot)
- TXXX3 *TCG@ (T cell antigen receptor, gamma)* (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
- UXXX1 *UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1)* (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)
- HLXX1 HLA Class I and II typing, low resolution (eg, antigen equivalents); *HLA-A, -B, -C, -DRB1/3/4/5, and -DQB1*
- HLXX2 *HLA-A, -B, and -DRB1/3/4/5* (eg, verification typing)
- HLXX3 HLA Class I typing, low resolution (eg, antigen equivalents); complete (ie, *HLA-A, -B, and -C*)
- HLXX4 one locus (eg, *HLA-A, -B, or -C*), each
- HLXX5 one antigen equivalent (eg, *B*27*), each
- HLXX6 HLA Class II typing, low resolution (eg, antigen equivalents); *HLA-DRB1/3/4/5 and -DQB1*

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- HLXX7 one locus (eg, *HLA-DRB1/3/4/5*, *-DQB1*, *-DQA1*, *-DPB1*, or *-DPA1*), each
- HLXX8 one antigen equivalent, each
- HLXX9 HLA Class I and II typing, high resolution (ie, alleles or allele groups), *HLA-A*, *-B*, *-C*, and *-DRB1*
- HLX10 HLA Class I typing, high resolution (ie, alleles or allele groups); complete (ie, *HLA-A*, *-B*, and *-C*)
- HLX11 one locus (eg, *HLA-A*, *-B*, or *-C*), each
- HLX12 one allele or allele group (eg, *B*57:01P*), each
- HLX13 HLA Class II typing, high resolution (ie, alleles or allele groups); one locus (eg, *HLA-DRB1*, *-DRB3*, *-DRB4*, *-DRB5*, *-DQB1*, *-DQA1*, *-DPB1*, or *-DPA1*), each
- HLX14 one allele or allele group (eg, *HLA-DQB1*06:02P*), each

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Codes not being surveyed at this time per RUC/CMS directive to CAP

(October 2010 CPT Meeting)

- Axxx1 ASPA (*aspartoacylase*) (eg, Canavan disease) gene analysis; common variants (eg, E285A, Y231X)
- Bxxx1 BCKDHB (*branched-chain keto acid dehydrogenase E1, beta polypeptide*) (eg, Maple syrup urine disease) gene analysis; common variants (eg, R183P, G278S, E422X)
- Bxxx5 BLM (*Bloom syndrome, RecQ helicase-like*) (eg, Bloom syndrome) gene analysis, 2281del6ins7 variant
- Fxxx3 FANCC (*Fanconi anemia, complementation group C*) (eg, Fanconi anemia, type C) gene analysis; common variant (eg, IVS4+4A>T)
- Gxxx1 G6PC (*glucose-6-phosphatase, catalytic subunit*) (eg, Glycogen storage disease, Type 1a, von Gierke disease) gene analysis; common variants (eg, R83C, Q347X)
- Gxxx2 GBA (*glucosidase, beta, acid*) (eg, Gaucher disease) gene analysis; common variants (eg, N370S, 84GG, L444P, IVS2+1G>A)
- Hxxx1 HEXA (*hexosaminidase A (alpha polypeptide)*) (eg, Tay-Sachs disease) gene analysis; common variants (eg, 1278insTATC, 1421+1G>C, G269S)
- Ixxx1 IKBKAP (*inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein*) (eg, familial dysautonomia) gene analysis; common variants (eg, 2507+6T>C, R696P)
- Mxxx1 MCOLN1 (*muco lipin 1*) (eg, Mucopolipidosis, type IV) gene analysis; common variants (eg, IVS3-2A>G, del6.4kb)
- Sxxx1 SMPD1 (*sphingomyelin phosphodiesterase 1, acid lysosomal*) (eg, Niemann-Pick disease, Type A) gene analysis; common variants (eg, R496L, L302P, fsP330)

(February 2011 CPT Meeting)

- Bxxx7 BRCA1, BRCA2 (*breast cancer 1 and 2*) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)
- Bxxx8 185delAG, 5385insC, 6174delT variants
- Bxxx9 uncommon duplication/deletion variants
- Bxx10 BRCA1 (*breast cancer 1*) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (ie, exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)
- Bxxx11 known familial variant
- Bxx12 BRCA2 (*breast cancer 2*) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis

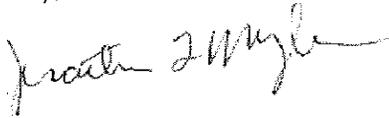
College of American Pathologists

- BXX13 known familial variant
- CXX10 Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)
- CXX11 interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities
- LXXX1 Long QT syndrome gene analyses (eg, *KCNQ1*, *KCNH2*, *SCN5A*, *KCNE1*, *KCNE2*, *KCNJ2*, *CACNA1C*, *CAV3*, *SCN4B*, *AKAP*, *SNTA1*, and *ANK2*); full sequence analysis
- LXXX2 known familial sequence variant
- LXXX3 duplication/deletion variants

If you have any questions or concerns, please contact Kim Chisolm, Assistant Director of Economic Affairs at (202) 354-7118 or kchisol@cap.org.

Thank you for providing us the opportunity to present this plan.

Sincerely,



Jonathan L. Myles, MD, FCAP
CAP RUC Advisor
College of American Pathologists

jlm/kmc
Sent via email

cc: Kenneth Simon, MD, MBA, CMS
Edith Hambrick, MD, JD, CMS
Susan Spires, MD, RUC Member
J. Allan Tucker, MD, RUC Alternate Member
Mark Synovec, MD, CPT Member
Sherry Smith, AMA RUC Staff
Roseanne Fischhoff, AMA RUC Staff
Kim Chisolm, CAP RUC Staff
Ayanna Wooding, CAP CPT Staff

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
5	ISSUE: Molecular Pathology Tier 2																		
6	TAB: 16 Revised Summary																		
7																			
8	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	TOTAL-TIME					utilization		
						MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX			
9	REF	99212	Level II Office Visit		0.035			0.48			16								
10	SVY	81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)	23	0.037	0.15	0.30	0.37	0.52	0.85		3	5	10	17.5	25		2000	
11	REC				0.037			0.37			10			10					
12																			
13																			
14	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	TOTAL-TIME					utilization		
						MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX			
15	REF	99212	Level II Office Visit		0.035			0.48			16								
16	SVY	81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using non-sequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)	21	0.029	0.12	0.41	0.55	0.85	1.39		4	10	19	20	35		2000	
17	REC				0.042			0.55			13			13					
18																			
19																			
20	Source	CPT	DESC	Resp	IWPUT	RVW					Total Time	Total-TIME					utilization		
						MIN	25th	MED	75th	MAX		MIN	25th	MED	75th	MAX			
21	REF	99212	Level II Office Visit		0.035			0.48			16								
22	REF	88291	Cytogenetics and molecular cytogenetics, interpretation and report		0.026			0.52			20								
23	SVY	81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)	26	0.039	0.20	0.52	0.68	0.98	1.50		5	11	17.5	20	35		2000	
24	REC				0.038			0.68			18			18					

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
7						RVW					Total	TOTAL-TIME					utilization		
8	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX		
25						RVW					Total	Total-TIME					utilization		
26	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX		
27						RVW					Total	Total-TIME					utilization		
28	REF	99213	Level III Office Visit		0.053			0.97			23								
29	SVY	81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)	22	0.028	0.25	0.53	0.85	1.15	1.50			12	15	30	30	50		2000
30	REC				0.028	0.85					30			30					
31						RVW					Total	Total-TIME					utilization		
32	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX		
33						RVW					Total	Total-TIME					utilization		
34	REF	99214	Level IV Office Visit		0.047			1.50			40								
35	REF	88307	Level V - Surgical pathology, gross and microscopic examination		0.034			1.59			47								
36	SVY	81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)	17	0.022	0.30	0.80	1.00	1.30	1.50			12	30	45	60	60		2000
37	REC				0.029	1.30					45			45					
38						RVW					Total	Total-TIME					utilization		
39	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time		MIN	25th	MED	75th	MAX		
40						RVW					Total	Total-TIME					utilization		
41	REF	99214	Level IV Office Visit		0.047			1.50			40								
42	REF	88307	Level V - Surgical pathology, gross and microscopic examination		0.034			1.59			47								
43	SVY	81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)	14	0.021	0.35	0.66	0.94	1.33	2.00			10	30	45	58.75	65		2000
44	REC				0.030	1.33					45			45					

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S
7						RVW					Total	TOTAL-TIME					utilization		
8	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX			
45																			
46	Source	CPT	DESC	Resp	IWPUT	RVW					Total	total-TIME					utilization		
47	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX			
48	REF	99214	Level IV Office Visit		0.047			1.50			40								
49	REF	88307	Level V - Surgical pathology, gross and microscopic examination	53	0.034			1.59			47			47					
50	SVY	81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)	16	0.023	0.52	1.00	1.39	1.55	2.80		15	38	60	82.5	90		1000	
51	REC				0.026			1.55			60			60					
52																			
53	Source	CPT	DESC	Resp	IWPUT	RVW					Total	total-TIME					utilization		
54	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX			
55	REF	99214	Level IV Office Visit		0.047			1.50			40								
56	REF	88307	Level V - Surgical pathology, gross and microscopic examination	53	0.034			1.59			47			47					
57	SVY	81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)	16	0.029	0.52	0.91	1.83	2.50	2.80		25	30	63	90	120		1000	
58	REC				0.025			1.59			63			63					
59																			
60	Source	CPT	DESC	Resp	IWPUT	RVW					Total	total-TIME					utilization		
61	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	MIN	25th	MED	75th	MAX			
62	REF	99214	Level IV Office Visit		0.047			1.50			40								
63	REF	88307	Level V - Surgical pathology, gross and microscopic examination	53	0.034			1.59			47			47					

SS Rec Summary

	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL
7																			
8																			
64																			
65																			
66																			

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

CPT Code:81400 Tracking Number AA1

Original Specialty Recommended RVU: **0.26**Presented Recommended RVU: **0.15**

Global Period: XXX

RUC Recommended RVU: **0.37**

CPT Descriptor: Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An asymptomatic newborn girl of Northern European descent is suspected to have medium chain acyl dehydrogenase deficiency (MCAD) on the basis of newborn screening. A sample of anticoagulated peripheral blood is submitted for genetic testing for the common ACADM gene K304E variant.

Percentage of Survey Respondents who found Vignette to be Typical: 82%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated. The genomic region containing the site of the K304E variant is amplified by PCR using primers that in the presence of the K304E variant, introduce an additional restriction endonuclease site into the amplicon. The PCR products undergo digestion with a restriction endonuclease, and the resulting fragments are separated using gel electrophoresis. The physician evaluates the patterns of the digestion fragments in relation to marker and control lanes to determine the patient's mutation and zygosity status. The physician composes a report which specifies the patient's mutation and zygosity status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP, Roger D. Klein, MD, JD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81400				
Sample Size:	450	Resp N:	23	Response: 5.1 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		15.00	50.00	50.00	200.00
Survey RVW:		0.15	0.30	0.37	0.52
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		3.00	5.00	10.00	17.50
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
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:	81400	Recommended Physician Work RVU: 0.37		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 7 % of respondents: 30.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81400	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	10.00	20.00	
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	10.00	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	2.57	3.57
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.14	3.43
--	------	------

Urgency of medical decision making	3.14	3.57
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.57	3.86
--------------------------	------	------

Physical effort required	2.57	3.14
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.29	3.43
---	------	------

Outcome depends on the skill and judgment of physician	2.86	3.71
--	------	------

Estimated risk of malpractice suit with poor outcome	3.29	3.29
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.14	3.43
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88291. The committee calculated an RVU based on using the median survey time and IWPUT for 88291. This number was compared to the survey's 25th percentile and the lower of the 25th percentile or calculated value based on comparison with the key reference code was recommended. The expert panel recommended an RVU of 0.26.

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) Stacking codes are currently used for the TC and 83912 for the PC. CAP can not provide absolute frequency data as the previous reporting of these services was methodology based and not analyte specific. The specialty society estimates that the total number of Tier 1 and Tier 2 professional services will fall in the 350,000 range for the Medicare population based on the current volume of 83912.

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 College of American Pathologists

How often? Sometimes

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? 2,000

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 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

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. 83912-26

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

CPT Code:81401 Tracking Number AA2

Original Specialty Recommended RVU: **0.36**Presented Recommended RVU: **0.22**

Global Period: XXX

RUC Recommended RVU: **0.55**

CPT Descriptor: Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using non-sequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old asymptomatic man with a family history of Huntington disease presents to his physician for predictive genetic testing for Huntington disease. A sample of anticoagulated peripheral blood is submitted for HTT mutation testing.

Percentage of Survey Respondents who found Vignette to be Typical: 62%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work:

Description of Intra-Service Work: High quality genomic DNA is isolated. The genomic region containing the site of the CAG trinucleotide repeat region that is expanded in Huntington Disease syndrome is then PCR-amplified and the fluorescently-labeled products subjected to capillary electrophoresis. The physician examines the electropherogram and compares the amplicon peaks to a sizing ladder to determine the number of CAG repeats within each allele. Based on this analysis, the physician determines the patient's HTT mutation status. The physician composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81401				
Sample Size:	450	Resp N:	21	Response: 4.6 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		10.00	20.00	65.00	200.00
Survey RVW:		0.12	0.41	0.55	0.85
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		4.00	10.00	19.00	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 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
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:	81401	Recommended Physician Work RVU: 0.55		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		14.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 1 Radiologic examination, chest, 2 views, frontal and lateral;

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 7 % of respondents: 33.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81401	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	14.00	20.00	
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	14.00	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	3.43
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.71	3.14
--	------	------

Urgency of medical decision making	3.29	3.57
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.14	3.71
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Physical effort required	2.57	3.43
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	3.43
---	------	------

Outcome depends on the skill and judgment of physician	3.00	3.86
--	------	------

Estimated risk of malpractice suit with poor outcome	3.29	3.57
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	3.14	3.57
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Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

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? 2,000
 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? 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

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. 83912-26

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

CPT Code:81402 Tracking Number AA3

Original Specialty Recommended RVU: **0.47**Presented Recommended RVU: **0.42**

Global Period: XXX

RUC Recommended RVU: **0.68**

CPT Descriptor: Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old girl of Turkish descent is seen by her physician for her third episode of fever accompanied by pleuritic chest pain, abdominal discomfort, and pain in the lower extremity joints. Her physical examination demonstrates a temperature of 38.5°C and dullness to percussion at the left lung base. Her abdomen is rigid with apparent rebound tenderness and diminished bowel sounds, and her left knee is warm and swollen with pain upon passive motion. Her white blood count, erythrocyte sedimentation rate and fibrinogen level are elevated. Familial Mediterranean fever is suspected, and a sample of anticoagulated peripheral blood is submitted for genetic testing for common variants in the MEFV gene.

Percentage of Survey Respondents who found Vignette to be Typical: 46%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated and subjected to multiplex PCR. Following exonuclease I and shrimp alkaline phosphatase treatment, a second reaction using allele specific primer extension (ASPE) amplifies either the normal or mutant allele sequences for 11 common MEFV variants. The fluorescently-tagged PCR products are separated by capillary electrophoresis. The physician evaluates the electropherogram comparing the relative sizes and peak heights of the PCR products to determine mutation and zygosity status. The physician composes a report which specifies the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81402				
Sample Size:	450	Resp N:	26	Response: 5.7 %	
Sample Type:	Convenience Additional Sample Information:				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	10.00	50.00	100.00	193.75	600.00
Survey RVW:	0.20	0.52	0.68	0.98	1.50
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	5.00	10.50	17.50	20.00	35.00
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: XXX Global Code

CPT Code:	81402	Recommended Physician Work RVU: 0.68		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		17.50		
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085
<u>CPT Descriptor 1</u> Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92083	XXX	0.50	RUC Time	7,539,975

CPT Descriptor 2 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)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 9 % of respondents: 34.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81402	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	18.00	20.00	
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	18.00	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	3.56	3.56
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.56	3.44
Urgency of medical decision making	3.44	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	4.00
Physical effort required	2.89	3.11

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.67	3.56
Outcome depends on the skill and judgment of physician	3.78	3.67
Estimated risk of malpractice suit with poor outcome	3.67	3.25

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	3.89	3.78
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

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

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
 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	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 83912-26

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

CPT Code:81403 Tracking Number AA4

Original Specialty Recommended RVU: **0.53**Presented Recommended RVU: **0.53**

Global Period: XXX

RUC Recommended RVU: **0.85**

CPT Descriptor: Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 72-year-old man with chronic myelogenous leukemia (CML) of several years duration on maintenance therapy with imatinib mesylate, experiences a greater than 1 log increase in his BCR/ABL1 transcript levels on repeat measurements. He reports adherence to his therapeutic regimen, and his imatinib level was found to be within the therapeutic range. Because of an apparent loss of response to imatinib, a sample of anticoagulated peripheral blood is submitted for ABL1 tyrosine kinase domain sequencing to assess for imatinib resistance mutations.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality total cellular RNA is isolated and stored under RNase-free conditions. Reverse transcriptase is used to convert RNA to cDNA. PCR amplification using primers for the BCR/ABL1 major breakpoint translocation is performed, followed by nested PCR amplification using internal primers flanking the tyrosine kinase domain region. The nested PCR products undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The physician evaluates the sequencing electropherograms for potential nucleotide sequence variants. The physician compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The physician omposes a report specifying the patient's ABL1 kinase domain mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81403				
Sample Size:	450	Resp N:	22	Response: 4.8 %	
Sample Type:	Convenience Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		10.00	35.00	50.00	142.50
Survey RVW:		0.25	0.53	0.85	1.15
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		12.00	15.00	30.00	30.00
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:

XXX Global Code

CPT Code:	81403	Recommended Physician Work RVU: 0.85		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		30.00		
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?

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88291	XXX	0.52	RUC Time

CPT Descriptor Cytogenetics and molecular cytogenetics, 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92083	XXX	0.50	RUC Time	2,580,775

CPT Descriptor 1 Visual field 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)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11000	000	0.60	RUC Time	115,072

CPT Descriptor 2 Debridement of extensive eczematous or infected skin; up to 10% of body surface

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 7 % of respondents: 31.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81403	<u>Key Reference CPT Code:</u> 88291	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	20.00	
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	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	3.00	3.71
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	3.43
--	------	------

Urgency of medical decision making	3.86	3.71
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.71	3.71
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Physical effort required	2.57	2.71
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.71	3.57
---	------	------

Outcome depends on the skill and judgment of physician	3.57	3.43
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.57
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	3.43	3.29
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000

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? 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

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. 83912-26

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

CPT Code:81404 Tracking Number AA5

Original Specialty Recommended RVU: **0.80**Presented Recommended RVU: **0.80**

Global Period: XXX

RUC Recommended RVU: **1.30**

CPT Descriptor: Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old woman who has relatives with head and neck paragangliomas presents to her physician complaining of an enlarging, otherwise asymptomatic right-sided neck mass. Imaging studies suggest a carotid body paraganglioma. The patient is referred to a surgeon, who suspects a hereditary paraganglioma-pheochromocytoma syndrome. An anticoagulated peripheral blood sample is submitted for SDHD gene sequencing.

Percentage of Survey Respondents who found Vignette to be Typical: 76%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 4 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The physician evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The physician compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The physician composes a report specifying the patient's mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81404				
Sample Size:	450	Resp N:	17	Response:	3.7 %
Sample Type:	Convenience Additional Sample Information:				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	20.00	40.00	50.00	100.00	500.00
Survey RVW:	0.30	0.80	1.00	1.30	1.50
Pre-Service Evaluation Time:			0.00		
Pre-Service Positioning Time:			0.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	12.00	30.00	45.00	60.00	60.00
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: XXX Global Code

CPT Code:	81404	Recommended Physician Work RVU: 1.30		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		45.00		
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88309	XXX	2.80	RUC Time

CPT Descriptor Level VI - Surgical pathology, gross and microscopic examination**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
29075	000	0.77	RUC Time	70,768

CPT Descriptor 1 Application, cast; elbow to finger (short arm)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11100	000	0.81	RUC Time	2,579,687

CPT Descriptor 2 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 6 % of respondents: 35.2 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81404	<u>Key Reference CPT Code:</u> 88309	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	45.00	90.00	
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	45.00	90.00	
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	4.17	3.83
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.50	3.33
--	------	------

Urgency of medical decision making	4.00	3.67
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.83	4.00
--------------------------	------	------

Physical effort required	3.50	3.17
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.83	4.00
---	------	------

Outcome depends on the skill and judgment of physician	4.50	4.33
--	------	------

Estimated risk of malpractice suit with poor outcome	3.83	4.00
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.50	3.83
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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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.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88309. The committee calculated an RVU based on using the median survey time and IWPUT for 88309. This number

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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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

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. 83912-26

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

CPT Code:81405 Tracking Number AA6

Original Specialty Recommended RVU: **0.90**Presented Recommended RVU: **0.85**

Global Period: XXX

RUC Recommended RVU: **1.33**

CPT Descriptor: Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old woman with a family history that includes several relatives with chromaffin tumors presents to her physician complaining of episodic headaches, palpitations, sweating, and anxiety. Plasma metanephrines are elevated, and an MRI reveals a mass in the region of the organ of Zuckerkandl, that upon resection is confirmed to be a paraganglioma. A hereditary paraganglioma-pheochromocytoma syndrome is suspected, and an anticoagulated peripheral blood sample is submitted for SDHB gene sequencing.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 8 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The physician evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The physician compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The physician composes a report specifying the patient's SDHB mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81405				
Sample Size:	450	Resp N:	14	Response: 3.1 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		10.00	50.00	50.00	71.25
Survey RVW:		0.35	0.66	0.94	1.03
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		10.00	30.00	45.00	58.75
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
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:	81405	Recommended Physician Work RVU: 1.33		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		45.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88309	XXX	2.80	RUC Time

CPT Descriptor Level VI - Surgical pathology, gross and microscopic examination**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
78306	XXX	0.86	RUC Time	466,066
<u>CPT Descriptor 1</u> Bone and/or joint imaging; whole body				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92012	XXX	0.92	RUC Time	6,568,221

CPT Descriptor 2 92012 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 5 % of respondents: 35.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81405	<u>Key Reference CPT Code:</u> 88309	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	45.00	90.00	
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	45.00	90.00	
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	4.60	3.80
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.60	3.80
--	------	------

Urgency of medical decision making	4.00	4.20
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.80	4.60
--------------------------	------	------

Physical effort required	2.60	3.00
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.60	4.60
---	------	------

Outcome depends on the skill and judgment of physician	4.80	4.80
--	------	------

Estimated risk of malpractice suit with poor outcome	4.40	4.40
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.80	4.00
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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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.*

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88309. The committee calculated an RVU based on using the median survey time and IWPUT for 88309. This number

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000

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? 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

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. 83912-26

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

CPT Code:81406 Tracking Number AA7

Original Specialty Recommended RVU: **1.00**Presented Recommended RVU: **1.00**

Global Period: XXX

RUC Recommended RVU: **1.55**

CPT Descriptor: Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10-month-old infant of mixed Ashkenazi Jewish ancestry experiences progressive muscle weakness with a loss of motor skills, decreased attentiveness, and an increased startle response. His pediatrician suspects a diagnosis of Tay-Sachs disease, and the patient is tested for the common Ashkenazi Jewish HEXA gene variants. The patient is found to be heterozygous for the +TATC1278 variant, but no additional common mutations are detected. An anticoagulated peripheral blood sample is submitted for HEXA sequencing to assess the patient for the presence of a second HEXA mutation.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 14 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The physician evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The physician compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The physician composes a report specifying the patient's HEXA mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81406				
Sample Size:	450	Resp N:	16	Response: 3.5 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	30.00	60.00	100.00
Survey RVW:		0.52	1.00	1.39	1.55
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		15.00	37.50	60.00	82.50
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
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:	81406	Recommended Physician Work RVU: 1.55		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		60.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88309	XXX	2.80	RUC Time

CPT Descriptor Level VI - Surgical pathology, gross and microscopic examination**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92012	XXX	0.92	RUC Time	6,568,221

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95819	XXX	1.08	RUC Time	303,721

CPT Descriptor 2 Electroencephalogram (EEG); including recording awake and asleep

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 7 % of respondents: 43.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81406	<u>Key Reference CPT Code:</u> 88309	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	60.00	90.00	
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	60.00	90.00	
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	4.43	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.43	3.71
--	------	------

Urgency of medical decision making	3.57	4.14
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.57	4.43
--------------------------	------	------

Physical effort required	3.43	3.57
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.29	4.14
---	------	------

Outcome depends on the skill and judgment of physician	4.57	4.57
--	------	------

Estimated risk of malpractice suit with poor outcome	4.14	4.14
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.43	3.86
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000

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? 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

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. 83912-26

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

CPT Code:81407 Tracking Number AA8

Original Specialty Recommended RVU: **1.12**Presented Recommended RVU: **1.18**

Global Period: XXX

RUC Recommended RVU: **1.59**

CPT Descriptor: Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 10-month-old girl with a family history of epilepsy is taken to her pediatrician after experiencing a febrile seizure in association with a viral infection. An SCN1A-related seizure disorder is suspected. An anticoagulated peripheral blood sample is submitted for SCN1A sequencing to assess the patient for the presence of a SCN1A-related seizure disorder mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 44%

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

Percent of survey respondents who stated they perform the procedure; In the hospital _____, 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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 30 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The physician evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The physician compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The physician composes a report specifying the patient's SCN1A mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81407				
Sample Size:	450	Resp N:	16	Response: 3.5 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	20.00	45.00	100.00
Survey RVW:		0.52	0.91	1.83	2.80
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		25.00	30.00	63.00	90.00
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: XXX Global Code

CPT Code:	81407	Recommended Physician Work RVU: 1.59		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		63.00		
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88309	XXX	2.80	RUC Time

CPT Descriptor Level VI - Surgical pathology, gross and microscopic examination**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
31231	000	1.10	RUC Time	361,190
<u>CPT Descriptor 1</u> Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
88333	XXX	1.20	RUC Time	49,122

CPT Descriptor 2 Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 7 % of respondents: 43.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81407	<u>Key Reference CPT Code:</u> 88309	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	63.00	90.00	
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	63.00	90.00	
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	4.29	3.71
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.29	3.29
--	------	------

Urgency of medical decision making	3.71	3.86
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.29	3.71
--------------------------	------	------

Physical effort required	3.57	3.14
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.00	4.00
---	------	------

Outcome depends on the skill and judgment of physician	4.14	4.14
--	------	------

Estimated risk of malpractice suit with poor outcome	3.86	3.86
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.43	3.43
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

The expert committee reviewed the survey data and compared it to the key reference code 88309. The committee calculated an RVU based on using the median survey time and IWP/UT for 88309. These numbers

Specialty	Frequency	Percentage	%
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

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. 83912-26

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

CPT Code:81408 Tracking Number AA9

Original Specialty Recommended RVU: **1.57**Presented Recommended RVU: **1.57**

Global Period: XXX

RUC Recommended RVU: **1.75**

CPT Descriptor: Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 16-month-old girl is found by her pediatrician to have mild axillary freckling and 2 large café-au-lait macules on routine physical examination. The history and physical examination is otherwise within normal limits. A diagnosis of neurofibromatosis is suspected. An anticoagulated peripheral blood sample is submitted for NF1 sequencing to assess the patient for the presence of a neurofibromatosis-related mutation.

Percentage of Survey Respondents who found Vignette to be Typical: 73%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: n/a

Description of Intra-Service Work: High quality genomic DNA is isolated from whole blood and subjected to 58 individual PCR amplification reactions. The PCR products from each reaction undergo bidirectional dideoxynucleotide chain termination sequencing using a capillary electrophoresis instrument. The physician evaluates the sequencing electropherograms for potential nucleotide sequence variants, insertions, deletions or other changes. The physician compares this evaluation with possible variations suggested by computer software to ensure that all abnormalities are identified. The physician composes a report specifying the patient's NF1 mutation status. The report is edited, signed and the results are communicated to appropriate caregivers.

Description of Post-Service Work: n/a

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	81408				
Sample Size:	450	Resp N:	11	Response: 2.4 %	
Sample Type:	Convenience	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		10.00	25.00	40.00	50.00
Survey RVW:		0.77	1.23	1.57	1.75
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		30.00	52.50	73.00	75.00
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
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:	81408	Recommended Physician Work RVU: 1.75		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		73.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88309	XXX	2.80	RUC Time

CPT Descriptor Level VI - Surgical pathology, gross and microscopic examination**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92014	XXX	1.42	RUC Time	10,614,906

CPT Descriptor 1 Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
92004	XXX	1.82	RUC Time	1,985,158

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 5 % of respondents: 45.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 81408	<u>Key Reference CPT Code:</u> 88309	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	73.00	90.00	
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	73.00	90.00
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	4.60	4.00
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.80	3.80
Urgency of medical decision making	4.00	4.40

Technical Skill/Physical Effort (Mean)

Technical skill required	5.00	4.60
Physical effort required	4.00	3.80

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.60	4.60
Outcome depends on the skill and judgment of physician	5.00	4.80
Estimated risk of malpractice suit with poor outcome	4.60	4.40

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
Intra-Service intensity/complexity	5.00	4.40
Post-Service intensity/complexity	0.00	0.00

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor, molecular pathology experts (MDs) and representatives from the general and academic pathology practice settings.

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,000

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? 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

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. 83912-26

CPT Code: Tier 1 (81200-81330) and Tier 2 (81400-81408)
AMA Specialty Society RVS Update Committee Recommendation

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

Meeting Date: April 2011

Global Period: XXX

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

CAP distributed practice expense surveys to various laboratories throughout the country, assuring that laboratories in various practice settings and sizes were included. The molecular pathologists and their lab managers (when applicable) submitted detailed practice expense recommendations to CAP for clinical labor, supplies, equipment and typical national batch size as well as the batch size in their particular laboratory.

CAP convened an expert panel, comprised of several molecular pathologists, members of the Economic Affairs Committee and the RUC subcommittee. The expert panel reviewed all the recommendations received. The panel adjusted the recommendations to adhere to applicable MoPath standards (i.e. confirm order, accession, extraction, set up, post time, etc). The panel also reviewed all the batch size data collected. The panel then made adjustments to clinical times, supplies and equipment based on batch size.

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

We did not use a comparison code for these recommendations.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The clinical activities for these molecular pathology codes often fall into several broad subcategories. They include (when applicable):

- Confirm Orders
- Accession
- Extraction
- Set Up
- Gel
- Post Processing
- Review and Prepare

To facilitate review by the PEAC committee, we included broad categories of activities on the excel sheets. During our presentation we are prepared to walk the committee through the detail

CPT Code: Tier 1 (81200-81330) and Tier 2 (81400-81408)

AMA Specialty Society RVS Update Committee Recommendation

for each procedure, as requested. Although the activities fall into broad categories, the order and terminology is often different.

Below is a summary of our recommendations:

Tier	CPT Code	CPT Code Descriptor	Batch Size	Rec Times
Tier 1	81206	<i>BCR/ABL 1; major breakpoint</i>	2	146
	81207	<i>BCR/ABL 1; minor breakpoint</i>	1	176
	81208	<i>BCR/ABL 1; other breakpoint</i>	1	176
	81220	<i>CFTR (cystic fibrosis); common variants</i>	5	40
	81221	<i>CFTR (cystic fibrosis); known familial variants</i>	1	211
	81222	<i>CFTR (cystic fibrosis); duplication/deletion variants</i>	1	237
	81223	<i>CFTR (cystic fibrosis); full gene sequence</i>	1	345
	81224	<i>CFTR (cystic fibrosis); intron 8 poly-T analysis</i>	5	66
	81240	<i>F2 gene analysis; 20210G>A variant</i>	5	39
	81241	<i>F5 gene analysis; Leiden variant</i>	5	39
	81243	<i>FMRI (Fragile X mental retardation 1) gene analysis; evaluation to detect abnormal alleles</i>	5	67
	81244	<i>FMRI (Fragile X mental retardation 1) gene analysis; characterization of alleles</i>	1	174
	81256	<i>HFE gene analysis; common variants</i>	5	68
	81270	<i>JAK2 gene analysis; V617F variant</i>	3	116
	81275	<i>KRAS gene analysis; variants in codons 12 and 13</i>	3	170
	81291	<i>MTHFR gene analysis; common variants</i>	2	141
	81315	<i>PML/RARalpha translocation analysis; common breakpoints</i>	1	150
81316	<i>PML/RARalpha translocation analysis; single breakpoints</i>	1	150	

**CPT Code: Tier 1 (81200-81330) and Tier 2 (81400-81408)
AMA Specialty Society RVS Update Committee Recommendation**

Tier	CPT Code	CPT Code Descriptor	Batch Size	Rec Times
Tier 2	81400	<i>Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)</i>	2	89
	81401	<i>Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)</i>	2	141
	81402	<i>Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)</i>	2	182
	81403	<i>Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicon using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)</i>	2	205
	81404	<i>Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)</i>	1	217
	81405	<i>Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)</i>	1	228
	81406	<i>Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)</i>	1	250
	81407	<i>Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)</i>	1	355
	81408	<i>Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)</i>	1	455

Intra-Service Clinical Labor Activities:

N/A

Post-Service Clinical Labor Activities:

- Enter results in lab information system after physician interpretation.
- Prepare, pack and transport specimens and records for in-house storage and external storage

CPT Code: Tier 1 (81200-81330) and Tier 2 (81400-81408)
AMA Specialty Society RVS Update Committee Recommendation

- Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste
- Clean Room
- Perform station maintenance including system rinse and dry
- Perform scheduled data management back-up



April 20, 2011

Sherry L. Smith, MS, CPA
Director
Physician Payment Policy and Systems
American Medical Association
515 North State Street
Chicago, Illinois 60654

Dear Ms. Smith,

This letter is in follow up to our conversation from last week in which we discussed some of the concerns of the RUC's Practice Expense Subcommittee concerning the molecular pathology codes.

One area of concern of the subcommittee members pertained to who was involved in determining the practice expense inputs. From our molecular experts, we compiled a list of laboratories for each code that performed the various assays. The expert panel then selected one laboratory to recommend practice expense inputs for each code. The laboratories selected represented a full spectrum of laboratory sizes as well as practice types. Academic institutions as well as large commercial laboratories were also included in the laboratories that provided inputs. Each laboratory also indicated to us what their typical batch size was and also recommended a typical batch size for all laboratories performing the test for that code.

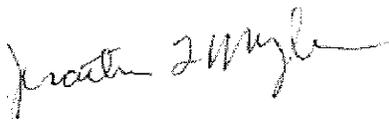
CAP's expert committee, which included members of our RBRVS workgroup as well as molecular experts, reviewed the practice expense inputs and batch sizes. Many of the steps are similar in various codes and allowed comparisons to be made. The batch sizes recommended to the RUC's Practice Expense Subcommittee from CAP were significantly larger than that recommended by the laboratories and the times for each step were typically a fraction of what the laboratory recommended.

In follow up to the Practice Expense Subcommittee's question concerning frequency, I indicated that in the existing coding scheme, it is not possible to reliably determine frequency data for the various codes. In fact, the AMA-CPT molecular pathology workgroup did investigate obtaining frequency data over a period of two years and ultimately concluded that reliable frequency data could not be obtained. Many laboratories would provide generalized percent distribution data, but would not provide specific numbers. However, the committee did conclude that the overwhelming highest volume test in frequency for molecular pathology was cystic fibrosis testing. This may not be applicable to the Medicare population. From review of the ICD 9 codes for the current way the professional services are coded (with CPT code 83912), it is not possible to reliably determine the frequency of molecular pathology codes under review. However, in our previous conversation, you indicated that the AMA would be willing to work with us using additional data available to the AMA to assist CAP in attempting to make this determination. For subcommittee guidance, anything with a batch size greater than two for any code listed in Tier 1 would be one of the higher frequency codes. Tier 2 codes are anticipated to be less than ten percent of total billed molecular pathology services and will not be considered high frequency codes. The batch size was increased in levels 1 through 4 to reduce times and maintain rank order with the rest of the Tier 2 codes.

College of American Pathologists

I hope these comments have been helpful to you. Please do not hesitate to contact me if you have any questions.

Cordially,

A handwritten signature in black ink that reads "Jonathan L. Myles". The signature is written in a cursive style with a long horizontal flourish at the end.

Jonathan L. Myles, MD, FCAP
RUC Advisor
College of American Pathologists

jlm/kmc
Sent via email

Revised Total Clinical Labor time Tabs 15 and 16

Tab 16: Tier 2 Codes					
CPT Code	RUC Number	Original Rec Time	Revised Rec Time	Original Batch Size	Revised Batch Size
L1	81400	89	53	2	4
L2	81401	141	75	2	4
L3	81402	182	83	2	4
L4	81403	205	102	2	4
L5	81404	217	109	1	2
L6	81405	228	118	1	2
L7	81406	250	129	1	2
L8	81407	355	158	1	2
L9	81408	455	199	1	2
Tab 15: Tier 1 Codes					
BXXX2	81206	146	93	2	2
BXXX3	81207	176	86	1	2
BXXX4	81208	176	86	1	2
CXXX1	81220	40	29	5	10
CXXX2	81221	211	109	1	2
CXXX3	81222	237	107	1	2
CXXX4	81223	345	155	1	2
CXXX5	81224	66	29	5	10
FXXX1	81240	39	32	5	8
FXXX2	81241	39	32	5	8
FXXX4	81243	67	45	5	8
FXXX5	81244	174	80	1	2
HXXX2	81256	68	28	5	8
JXXX1	81270	116	37	3	5
KXXX1	81275	170	44	3	5
MXXX2	81291	141	64	2	4
PXXX1	81315	150	93	1	2
PXXX2	81316	150	93	1	2

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81400		
	Meeting Date: April 2011 Specialty: Pathology	<i>Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)</i>		
2	<i>Adjusted for Batch Size - 4</i>			
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			53
6	<i>Lab Tech</i>	L033A		18
7	<i>Cytotechnologist</i>	L045A		35
8	TOTAL PRE-SERV CLINICAL LABOR TIME			42
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set Up	L045A	Cytotechnologist	10
17	Retrieve sample, verify order/position on tray map			
18	Prepare cocktail and add to samples			
19	Set up Thermocycler and load samples			
20	Remove samples from thermocycler			
21	PCR Gel	L045A	Cytotechnologist	13
22	Prepare Gel			
23	Load Gel			
24	Gel and Label picture			
25	PCR Post Processing	L045A	Cytotechnologist	6
26	Prepare and add digest mix			
27	Pulse samples			
28	Set up thermocycler			
29	Load samples on thermocycler			
30	Remove samples from thermocycler			
31	Pulse samples			
32	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
33	End: When specimen is ready for examination by physician			
34	Service Period			
35				
36	Post-Service Period			
37	Start: When specimen examination by physician is complete			
38	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
39	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
40	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
41	Clean Room	L033A	Lab Tech	2
42	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
43	Perform scheduled data management back-up	L033A	Lab Tech	1
44	End: When specimen, chemical waste and record handling is complete			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81400		
	Meeting Date: April 2011 Specialty: Pathology	<i>Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)</i>		
2	Adjusted for Batch Size - 4			
3		CMS Code	Staff Type	Minutes
45	SUPPLIES		Type of Unit	No. of Units
46	DNA isolation kit		reaction	1
47	Gown	SB027	item	0.5
48	Gloves, nonsterile	SB022	pair	2.5
49	Bleach 10%	SL020	ml	0.75
50	High fidelity hot start Taq polymerase		ul	0.5
51	PCR buffer		ul	15
52	MgCl2		ul	4.5
53	F Primer		ul	3
54	R Primer		ul	3
55	dNTPs		ul	3
56	Taq1 restriction enzyme		ul	3
57	Agarose ultrapure		g	0.8
58	Agarose NuSieve GTG		g	1.6
59	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
60	Milli-Q water		ml	35
61	Masking tape		inches	12
62	DNA ladder, 100bp		ul	5
63	Loading buffer with dye	SL210	ul	20
64	BSA 100X		ul	3
65	PCR grade water	SL244	ul	102
66	0.2 mL PCR tubes		each	6
67	2 mL plastic tubes		each	2
68	Restriction enzyme buffer		ul	60
69	Milli-Q water		ml	35
70	Extraction tubs		each	4
71	15 mL centrifuge tubes	SL241		2
72	50 mL centrifuge tubes			2
73	Barrier pipet tips 200 uL		item	22
74	Barrier pipet tips 1000 uL		item	4
75	Barrier pipet tips 20 uL		item	55
76	0.5 mL tube		each	3
77	Extraction tip assembly		each	1
78				
79	Equipment			Time in Use Minutes
80	Analytical balance		EP004	1
81	Centrifuge		EP059	2
82	Cooling block			1
83	Gel electrophoresis apparatus with power supply		EP063	30
84	Gel imaging system		EP062	2
85	Micro-volume spectrophotometer with specimen retention technology			1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	CPT Code: 81401		
2	Meeting Date: April 2011 Specialty: Pathology Adjusted for Batch Size - 4	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)		
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			75
6	Lab Tech	L033A		18
7	Cytotechnologist	L045A		57
8	TOTAL PRE-SERV CLINICAL LABOR TIME			64
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L045B	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	Extraction (run set up)			
17	Extraction (aliquoting, instrument set up, DNA concentration)			
18	PCR Set Up	L045A	Cytotechnologist	13
19	Generate run on computer, generate a run on computer, and prepare tray map			
20	Prepare tray map (calculation reagent volumes, lots, expiration dates)			
21	Retrieve sample, position on tray map			
22	Thaw reagents (PCR premix and primer sets)/Prepare Master mix			
23	Aliquot mastermix and sample to well			
24	Vortex and spin sample			
25	Set up Thermocycler and load samples			
26	Remove samples from thermocycler			
27	PCR Gel	L045A	Cytotechnologist	13
28	Prepare Gel			
29	Load Gel			
30	Gel and Label picture			
31	PCR Post Processing	L045A	Cytotechnologist	25
32	Post-PCR -Prepare loading master mix			
33	Dilute sample			
34	Denature/cool samples			
35	Load sample onto instrument			
36	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
37	End: When specimen is ready for examination by physician			
38	Service Period			
39				
40	End: When specimen is ready for examination by physician			
41	Post-Service Period			
42	Start: When specimen examination by physician is complete			
43	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
44	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
45	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
46	Clean Room	L033A	Lab Tech	2
47	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
48	Perform scheduled data management back-up	L033A	Lab Tech	1
49	End: When specimen, chemical waste and record handling is complete			
50	SUPPLIES		Type of Unit	No. of Units
51	DNA isolation kit		reaction	1
52	Gown	SB027	item	0.5
53	Gloves, nonsterile	SB022	pair	2.5
54	Bleach 10%	SL020	ml	0.75
55	High fidelity hot start Taq polymerase		ul	0.75
56	PCR buffer		ul	15
57	MgCl2		ul	4.5
58	F Primer, fluorescent		ul	3
59	R Primer, fluorescent		ul	3
60	dNTPs		ul	3
61	PCR grade water	SL244	ul	102
62	Ethidium bromide (10 mg/ml)	SL239	ul	5
63	DNA ladder, 100bp		ul	5
64	Loading buffer with dye	SL210	ul	20
65	Agarose ultrapure		g	0.8
66	Agarose NuSieve GTG		g	1.6
67	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
68	Milli-Q water		ml	40
69	Masking tape		inch	12
70	0.2 mL strip tubes		each	2
71	0.5 mL microcentrifuge tubes			2
72	2 mL plastic tubes		each	2
73	PCR grade water	SL244	ul	228
74	Barrier pipet tips1000 uL		ul	1
75	Barrier pipet tips 200 uL		each	3
76	Barrier pipet tips 20uL		each	10
77	Running buffer		ul	10
78	Formamide	SL192	ul	30
79	Size standard		ul	2.6
80	Optical 96 well reaction plate		each	1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	CPT Code: 81401		
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 4</i>	<i>Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)</i>		
3		CMS Code	Staff Type	Minutes
81	Septa		each	0.3
82	Polymer		ul	3:40
83	Capillary array		item	1/200
84	Cassette		each	1
85	Extraction tubs		each	4
86	Extraction tip assembly		each	1
87				
88	Equipment			Time in Use Minutes
89	Analytical balance		EP004	1
90	Capillary electrophoresis instrument - fragment analysis			15
91	Capillary electrophoresis instrument - fragment analysis software			15
92	Centrifuge		EP059	2
93	Cooling block			1
94	Gel electrophoresis apparatus with power supply		EP063	8

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81402		
2	Meeting Date: April 2011 Specialty: Pathology Adjusted for Batch Size - 4	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)		
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			83
6	Lab Tech	L033A		18
7	Cytotechnologist	L045A		65
8	TOTAL PRE-SERV CLINICAL LABOR TIME			72
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	place blood sample on rocker			
17	Place tips and microtiter plate on Qiagen 9604			
18	Remove cap from blood tube			
19	place blood sample in Qiagen 9604 rack and allow instrument to read bar code and aliquot blot into microtiter plate			
20	Create plate map for testing and IT interface			
21	Cap blood tube and return specimen to refrigerator until testing completed			
22	Place tips, reagents and microtiter plates on Qiagen M96			
23	Place microtiter plate with blood sample on Qiagen M96			
24	Allow instrument to extract DNA			
25	discard DNA extraction waste (liquids and solids)			
26	PCR Set Up	L045A	Cytotechnologist	15
27	combine reagents for PCR master mix			
28	Place tips, PCR reagents and PCR reaction plate on Biomek 2000			
29	Remove extracted DNA from Qiagen M96 and place on Biomek 2000			
30	Allow instrument to set up PCR reaction			
31	Cover plate with sealing mat			
32	discard Biomek 2000 tips from PCR set up			
33	Place PCR reaction plate in ABI 9700 thermal cycler, enter Accutype PCR program, and allow instrument to perform PCR			
34	Post PCR Processing 1	L045A	Cytotechnologist	16
35	combine reagents for 1st digest master mix			
36	Place tips, 1st digest reagents, 1st digest plate, and PCR reaction plate on Biomek 2000			
37	Allow instrument to set up 1st digest reaction			
38	Cover plate with sealing mat			
39	discard Biomek 2000 tips from 1st digest set up			
40	Place 1st digest reaction plate in ABI 9700 thermal cycler, enter 1st digest program, and allow instrument to perform 1st digest reaction			
41	combine reagents for SNAP master mix			
42	Place tips, SNAP reagents, SNAP plate, and 1st digest reaction plate on Biomek 2000			
43	Allow instrument to set up SNAP reaction			
44	Cover plate with sealing mat			
45	discard Biomek 2000 tips from SNAP set up			
46	Place SNAP reaction plate in ABI 9700 thermal cycler, enter SNAP program, and allow instrument to perform SNAP reaction			
47	Post PCR Processing 2	L045A	Cytotechnologist	8
48	combine reagents for 2nd digest master mix			
49	Place tips, 2nd digest reagents, 2nd digest plate, and SNAP reaction plate on Biomek 2000			
50	Allow instrument to set up 2nd digest reaction			
51	Cover plate with sealing mat			
52	discard Biomek 2000 tips from 2nd digest set up			
53	Place 2nd digest reaction plate in ABI 9700 thermal cycler, enter 2nd digest program, and allow instrument to perform 2nd digest reaction			
54	Post PCR Processing 3	L045A	Cytotechnologist	20
55	combine reagents for loading master mix			
56	Place tips, 2nd digest plate, loading plate, dilution plate, nuclease free water, ROX size standard and Hi-Di foramide on Biomek 2000 and allow instrument to pipet reagents			
57	Place 3130 loading plate on ABI 9700, enter denature program, and allow thermal cycler to denature			
58	Cover plate with 96-well septa			
59	discard Biomek 2000 tips from loading set up			
60	Prepare 3130 instrument for capillary electrophoresis (upload plate map, add buffer, POP4, capillary array, 16-well septa)			
61	Place loading reaction plate into cassette and place on 3130 instrument			
62	Allow instrument to perform capillary electrophoresis			
63	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
64	End: When specimen is ready for examination by physician			
65	Service Period			
66				
67	Post-Service Period			
68	Start: When specimen examination by physician is complete			
69	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
70	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
71	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
72	Clean Room	L033A	Lab Tech	2
73	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
74	Perform scheduled data management back-up	L033A	Lab Tech	1

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81402		
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 4</i>	<i>Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon)</i>		
3		CMS Code	Staff Type	Minutes
75	End: When specimen, chemical waste and record handling is complete			
76	SUPPLIES		Type of Unit	No. of Units
77	DNA isolation		reaction	1
78	Gown	SB027	item	0.5
79	Gloves, nonsterile	SB022	pair	2.5
80	Bleach 10%	SL020	ml	0.75
81	100% ethanol	SL189	ml	0.44
82	1000uL graduated barrier pipet tips		each	3
83	10mL serological pipet		item	1
84	11 multiplex extension Primers		ul	1
85	11 Primer Pairs		ul	2 uL
86	20 uL barrier pipe tips		each	7
87	200uL barrier pipet tips		each	3
88	20uL pipet barrier tips		each	4
89	25 mL pipettes		item	1
90	250uL barrier pipet tips		each	3
91	8-cap strips		each	0.13
92	96 well PCR Plate		each	0.03
93	BSA 100 ug/mL		ul	2
94	Calf Intestinal Phosphatase, 1000U		item	3
95	Cap for blood tube		each	1
96	Capillary Array 16X36Cm		item	0.063
97	Capillary electrophoresis buffer		ul	0.007
98	Capillary electrophoresis polymer		ul	5.2
99	Capillary electrophoresis size standard		ul	0.5
100	Disposable culture tubes 12X75		each	0.01
101	DNA extraction instrument tips		item	6
102	dNTPs		ul	0.4
103	Exonuclease 1, 5000Unit/Ea		ul	2
104	Formamide	SL192	item	0.01
105	green microtiter plates		each	0.01
106	High fidelity hot start taq polymerase		ul	0.3
107	Liquid handling instrument tips		item	1
108	Microcentrifuge tubes	SL240	each	1
109	Multiplex extension mix		ul	5
110	Plate Sealers		each	0.01
111	Reagent, Water, Sterile Nuclease Free, 100MI	SL251	ul	26
112	Sealing mat		each	0.03
113	Septa Strip Tray 96 well		item	0.04
114	Strip Tube, 8 Per Strip		each	0.1
115	Tube, Thin Wall Pcr 8 Strip W/Cap 200uL		each	0.1
116	U bottom microtiter plates		each	0.01
117	yellow microtiter plates		each	0.01
118				
119	Equipment			Time in Use Minutes
120	Capillary electrophoresis instrument - fragment analysis			15

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		81403	
2	Meeting Date: April 2011 Specialty: Pathology <i>Adjusted for Batch Size - 4</i>			<i>Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicon using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)</i>
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			102
6	<i>Lab Tech</i>	L033A		18
7	<i>Cytotechnologist</i>	L045A		84
8	TOTAL PRE-SERV CLINICAL LABOR TIME			91
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	Preserve RNA	L045A	Cytotechnologist	2
16	Preparing work area, materials, documentation, and labeling			
17	Red blood cell lysis, white blood cell lysis, and freezing of specimen			
18	RNA isolation	L045A	Cytotechnologist	2
19	Preparing work area, materials, and documentation			
20	Isolating and quantitating RNA			
21	mRNA Preparation	L045A	Cytotechnologist	8
22	Adding reagents and mixing			
23	Incubating, washing, centrifuging, and quantitating			
24	cDNA preparation	L045A	Cytotechnologist	10
25	Preparing reagents, materials, controls, documentation			
26	Assembling master mix, adding to tubes along with specimen and controls; mixing and incubating			
27	Decontaminating area with bleach			
28	Initial PCR reaction	L045A	Cytotechnologist	10
29	Preparing reagents, documentation, labeling			
30	Preparing master mix, adding to reaction tubes along with cDNA, mixing, programming thermal cycler, adding and removing reaction tubes from thermal cycler			
31	Nested PCR reaction	L045A	Cytotechnologist	10
32	Preparing work area, reagents, documentation, labeling			
33	Assembling nested PCR master mix, adding to reaction tubes along with amplified products, programming thermal cycler, adding and removing reaction tubes from thermal cycler			
34	Confirm PCR products	L045A	Cytotechnologist	13
35	Preparing samples for electrophoresis, reagents, documentation and preparing agarose gel			
36	Loading samples into agarose gel, performing electrophoresis, photographing gel in darkroom, and decontaminating transilluminator			
37	PCR Clean-up	L045A	Cytotechnologist	3
38	Preparing documentation and labeling			
39	Adding ExoSAP-IT, mixing, programming thermal cycler adding and removing from thermal cycler			
40	Cycle Sequencing Reaction	L045A	Cytotechnologist	10
41	Preparing reagents, documentation, and labeling plate			
42	Assembling master mix, adding to plate along with reagents, amplicons, mixing, centrifuging programming thermal cycler, adding and removing from thermal cycler			
43	Ethanol Precipitation	L045A	Cytotechnologist	8
44	Preparing reagents, including fresh 70% ethanol, and documentation			
45	Adding reagents, mixing, centrifuging, incubating, heating, cooling			
46	Sequencing	L045A	Cytotechnologist	6
47	Preparing documentation and entering run parameters			
48	Placing plate in sequencer and running instrument, exporting data to file			
49	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
50	End: When specimen is ready for examination by physician			
51	Service Period			
52				
53	Post-Service Period			
54	Start: When specimen examination by physician is complete			
55	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
56	Prepare, pack and transport specimens and records for in-house storage and external storage		Lab Tech	2
57	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
58	Clean Room	L033A	Lab Tech	2
59	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
60	Perform scheduled data management back-up	L033A	Lab Tech	1
61	End: When specimen, chemical waste and record handling is complete			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation		81403	
2	Meeting Date: April 2011 Specialty: Pathology Adjusted for Batch Size - 4		<i>Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicon using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)</i>	
3		CMS Code	Staff Type	Minutes
62	SUPPLIES		Type of Unit	No. of Units
63	RNA isolation kit		reaction	1
64	Gown	SB027	item	0.5
65	Bleach 10%	SL020	ml	0.75
66	High fidelity hot start Taq polymerase		ul	0.5
67	PCR buffer		ul	10
68	MgCl2		ul	3
69	F Primer		ul	2
70	R Primer		ul	2
71	Ethidium bromide (10 mg/ml)	SL239	ul	5
72	DNA ladder, 100bp		ul	5
73	Loading buffer with dye	SL210	ul	20
74	Agarose ultrapure		g	0.8
75	Agarose NuSieve GTG		g	1.6
76	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	1300
77	Masking tape		inch	12
78	96 Capillary array		item	1/200
79	Cycle sequencing kit		ul	16
80	Cycle sequencing purification plates		each	1
81	Optical 96 well reaction plate		each	1
82	0.2 ml strip tubes		each	3
83	Milli-Q water		ml	35
84	Exonuclease I / Shrimp alkaline phosphatase		ul	2
85	Septa		each	0.3
86	Sequencing cassette		each	1
87	Polymer		ul	1/125
88	15 mL centrifuge tubes	SL241		2
89	50 mL centrifuge tubes			2
90	2 mL plastic tubes		each	1
91	Running buffer		ul	80
92	0.5 mL microcentrifuge tubes			2
93	Extraction tubs		each	4
94	dNTPs		uL	6
95	EDTA		item	6
96	Filter Micropipet Tip, 10uL		item	57
97	Filter Micropipet Tip, 20 uL		item	36
98	Filter Micropipet Tip, 200uL		item	17
99	Formamide	SL192	uL	100
100	Gloves, Nonsterile, Latex	SB022	pair	2.5
101	Gloves, Nonsterile, Nitrile	SB023	pair	0.5
102	Gown, Impervious, staff	SB027	item	0.5
103	Kimwipe	SM027	item	6
104	Micropipet Tip, 1000uL		item	7
105	PCR Grade Water	SL244	uL	204
106	Reverse Transcription Kit		item	6
107	RNase Zap		mL	30
108	Sealing Foil		each	2
109	Sequencing Primers, 3 uM, HPLC purified		uL	6
110	Transfer Pipet		item	1
111	Extraction tubs		each	4
112	Extraction tip assembly		each	1
113				
114	Equipment			Time in Use Minutes
115	Analytical balance		EP004	1
116	Capillary electrophoresis instrument, 96 well - sequencing			12
117	Capillary electrophoresis sequencing software			12
118	Centrifuge		EP059	2
119	Cooling block			2
120	Gel electrophoresis apparatus with power supply		EP063	15
121	Gel imaging system		EP062	2
122	Micro-volume spectrophotometer with specimen retention technology			1
123	Nucleic acid extraction instrument			9
124	Nucleic acid workstation			20
125	Pipet set		EP071	30
126	Real-time PCR instrument			11
127	Thermal cycler			13
128	Water bath		EP043	5

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81404		
2	Meeting Date: April 2011 Specialty: Pathology Typical Batch Size - 2	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)		
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			109
6	Lab Tech	L033A		18
7	Cytotechnologist	L045A		91
8	TOTAL PRE-SERV CLINICAL LABOR TIME			98
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set-up	L045A	Cytotechnologist	25
17	PCR Gel (L5: 4products)	L045A	Cytotechnologist	15
18	PCR Post Processing	L045A	Cytotechnologist	45
19	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
20	End: When specimen is ready for examination by physician			
21	Service Period			
22				
23	Post-Service Period			
24	Start: When specimen examination by physician is complete			
25	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
26	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
27	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
28	Clean Room	L033A	Lab Tech	2
29	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
30	Perform scheduled data management back-up	L033A	Lab Tech	1
31	End: When specimen, chemical waste and record handling is complete			
32	SUPPLIES		Type of Unit	No. of Units
33	DNA isolation kit		reaction	1
34	Gown	SB027	item	1
35	Gloves, nonsterile	SB022	pair	5
36	Bleach 10%	SL020	ml	1.5
37	High fidelity hot start Taq polymerase		ul	2
38	PCR buffer		ul	40
39	MgCl2		ul	12
40	F Primer X 4		ul	2
41	R Primer X 4		ul	2
42	dNTPs		ul	8
43	PCR grade water	SL244	ul	272
44	Ethidium bromide (10 mg/ml)	SL239	ul	5
45	DNA ladder, 100bp		ul	5
46	Loading buffer with dye	SL210	ul	20
47	Agarose ultrapure		g	0.8
48	Agarose NuSieve GTG		g	1.6
49	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
50	Masking tape		inch	12
51	96 Capillary array		item	1/200
52	Cycle sequencing kit		ul	64
53	Cycle sequencing purification plates		each	1
54	Optical 96 well reaction plate		each	1
55	Sequencing primers		ul	16
56	0.2 mL strip tubes		each	1
57	0.2 ml PCR tubes		each	5
58	Milli-Q water		ml	35
59	Exonuclease I / Shrimp alkaline phosphatase		ul	8
60	Septa		each	0.3
61	Sequencing cassette		each	1
62	Polymer		ul	4/125
63	Formamide	SL192	ul	120

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81404		
2	Meeting Date: April 2011 Specialty: Pathology <i>Typical Batch Size - 2</i>	<i>Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)</i>		
3		CMS Code	Staff Type	Minutes
64	15 mL centrifuge tubes	SL241		2
65	50 mL centrifuge tubes			2
66	2 mL plastic tubes		each	4
67	Running buffer		ul	80
68	0.5 mL microcentrifuge tubes			6
69	Barrier pipet tips 1000 uL		ul	1
70	Barrier pipet tips 200 uL		each	9
71	Barrier pipet tips 20uL		each	60
72	Extraction tubs		each	4
73	Extraction tip assembly		each	1
74				
75	Equipment			Time in Use Minutes
76	Analytical balance		EP004	1
77	Capillary electrophoresis instrument, 96 well - sequencing			12
78	Capillary electrophoresis sequencing software			12
79	Centrifuge		EP059	3
80	Cooling block			3

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81405		
2	Meeting Date: April 2011 Specialty: Pathology Typical Batch Size - 2	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)		
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			118
6	Lab Tech	L033A		18
7	Cytotechnologist	L045A		100
8	TOTAL PRE-SERV CLINICAL LABOR TIME			107
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set-up	L045A	Cytotechnologist	27
17	PCR Gel (L6: 8products)	L045A	Cytotechnologist	17
18	PCR Post Processing 1	L045A	Cytotechnologist	20
19	Post PCR Processing 2	L045A	Cytotechnologist	15
20	Post PCR Processing 3	L045A	Cytotechnologist	15
21	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
22	End: When specimen is ready for examination by physician			
23	Service Period			
24				
25	Post-Service Period			
26	Start: When specimen examination by physician is complete			
27	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
28	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
29	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
30	Clean Room	L033A	Lab Tech	2
31	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
32	Perform scheduled data management back-up	L033A	Lab Tech	1
33	End: When specimen, chemical waste and record handling is complete			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81405		
2	Meeting Date: April 2011 Specialty: Pathology <i>Typical Batch Size - 2</i>	<i>Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons)</i>		
3		CMS Code	Staff Type	Minutes
34	SUPPLIES		Type of Unit	
35	DNA isolation kit		reaction	1
36	Gown	SB027	item	1
37	Gloves, nonsterile	SB022	pair	5
38	Bleach 10%	SL020	ml	1.5
39	High fidelity hot start Taq polymerase		ul	4
40	PCR buffer		ul	80
41	MgCl ₂		ul	24
42	F Primer X 8		ul	2
43	R Primer X 8		ul	2
44	dNTPs		ul	16
45	PCR grade water	SL244	ul	544
46	Ethidium bromide (10 mg/ml)	SL239	ul	5
47	DNA ladder, 100bp		ul	5
48	Loading buffer with dye	SL210	ul	20
49	Agarose ultrapure		g	0.8
50	Agarose NuSieve GTG		g	1.6
51	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
52	Masking tape		inch	12
53	96 Capillary array		item	1/200
54	Cycle sequencing kit		ul	128
55	Cycle sequencing purification plates		each	1
56	Optical 96 well reaction plate		each	1
57	Sequencing primers		ul	32
58	0.2 mL strip tubes		each	2
59	0.2 ml PCR tubes		each	9
60	Milli-Q water		ml	35
61	Exonuclease I / Shrimp alkaline phosphatase		ul	16
62	Septa		each	0.3
63	Sequencing cassette		each	1
64	Polymer		ul	8/125
65	Formamide	SL192	ul	240
66	15 mL centrifuge tubes	SL241		2
67	50 mL centrifuge tubes			2
68	2 mL plastic tubes		each	8
69	Running buffer		ul	80
70	0.5 mL microcentrifuge tubes			12
71	Barrier pipet tips 1000 uL		ul	2
72	Barrier pipet tips 200 uL		each	18
73	Barrier pipet tips 20uL		each	120
74	Extraction tubs		each	4
75	Extraction tip assembly		each	1
76				
77	Equipment			Time in Use Minutes
78	Analytical balance		EP004	1
79	Capillary electrophoresis instrument, 96 well - sequencing			24
80	Capillary electrophoresis sequencing software			24
81	Centrifuge		EP059	3
82	Cooling block			3
83	Gel electrophoresis apparatus with power supply		EP063	15
84	Gel imaging system		EP062	4

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81406		
2	Meeting Date: April 2011 Specialty: Pathology <i>Typical Batch Size - 2</i>	<i>Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)</i>		
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			129
6	<i>Lab Tech</i>	L033A		18
7	<i>Cytotechnologist</i>	L045A		111
8	TOTAL PRE-SERV CLINICAL LABOR TIME			118
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set-up	L045A	Cytotechnologist	35
17	PCR Gel (L7: 14products)	L045A	Cytotechnologist	20
18	PCR Post Processing 1	L045A	Cytotechnologist	30
19	Post PCR Processing 2	L045A	Cytotechnologist	20
20	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
21	End: When specimen is ready for examination by physician			
22	Service Period			
23				
24	Post-Service Period			
25	Start: When specimen examination by physician is complete			
26	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
27	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
28	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
29	Clean Room	L033A	Lab Tech	2
30	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
31	Perform scheduled data management back-up	L033A	Lab Tech	1
32	End: When specimen, chemical waste and record handling is complete			

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81406		
2	Meeting Date: April 2011 Specialty: Pathology <i>Typical Batch Size - 2</i>	<i>Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)</i>		
3		CMS Code	Staff Type	Minutes
33	SUPPLIES		Type of Unit	
34	DNA isolation kit		reaction	1
35	Gown	SB027	item	1
36	Gloves, nonsterile	SB022	pair	5
37	Bleach 10%	SL020	ml	1.5
38	High fidelity hot start Taq polymerase		ul	7
39	PCR buffer		ul	140
40	MgCl2		ul	42
41	F Primer X 14		ul	2
42	R Primer X 14		ul	2
43	dNTPs		ul	28
44	PCR grade water	SL244	ul	952
45	Ethidium bromide (10 mg/ml)	SL239	ul	5
46	DNA ladder, 100bp		ul	5
47	Loading buffer with dye	SL210	ul	20
48	Agarose ultrapure		g	0.8
49	Agarose NuSieve GTG		g	1.6
50	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	100
51	Masking tape		inch	12
52	96 Capillary array		item	1/200
53	Cycle sequencing kit		ul	224
54	Cycle sequencing purification plates		each	1
55	Optical 96 well reaction plate		each	1
56	Sequencing primers		ul	56
57	0.2 mL strip tubes		each	4
58	0.2 ml PCR tubes		each	15
59	Milli-Q water		ml	35
60	Exonuclease I / Shrimp alkaline phosphatase		ul	28
61	Septa		each	0.3
62	Sequencing cassette		each	1
63	Polymer		ul	14/125
64	Formamide	SL192	ul	420
65	15 mL centrifuge tubes	SL241		2
66	50 mL centrifuge tubes			2
67	2 mL plastic tubes		each	14
68	Running buffer		ul	80
69	0.5 mL microcentrifuge tubes			25
70	Barrier pipet tips 1000 uL		ul	4
71	Barrier pipet tips 200 uL		each	32
72	Barrier pipet tips 20uL		each	200
73	Extraction tubs		each	4
74	Extraction tip assembly		each	1
75				
76	Equipment			Time in Use Minutes
77	Analytical balance		EP004	1
78	Capillary electrophoresis instrument - sequencing			36
79	Capillary electrophoresis sequencing software			36
80	Centrifuge		EP059	3
81	Cooling block			3
82	Gel electrophoresis apparatus with power supply		EP063	15
83	Gel imaging system		EP062	4
84	Micro-volume spectrophotometer with specimen retention technology			1
85	Nucleic acid extraction instrument			5

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81407		
2	Meeting Date: April 2011 Specialty: Pathology <i>Typical Batch Size - 2</i>	<i>Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)</i>		
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			158
6		<i>Lab Tech</i>	L033A	18
7		<i>Cytotechnologist</i>	L045A	140
8	TOTAL PRE-SERV CLINICAL LABOR TIME			147
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set-up	L045A	Cytotechnologist	36
17	PCR Gel (L8: 28products)	L045A	Cytotechnologist	20
18	PCR Post Processing 1	L045A	Cytotechnologist	37
19	Post PCR Processing 2	L045A	Cytotechnologist	31
20	Post PCR Processing 3	L045A	Cytotechnologist	10
21	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
22	End: When specimen is ready for examination by physician			
23	Service Period			
24				
25	Post-Service Period			
26	Start: When specimen examination by physician is complete			
27	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
28	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
29	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
30	Clean Room	L033A	Lab Tech	2
31	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
32	Perform scheduled data management back-up	L033A	Lab Tech	1
33	End: When specimen, chemical waste and record handling is complete			
34	SUPPLIES		Type of Unit	
35	DNA isolation kit		reaction	1
36	Gown	SB027	item	1
37	Gloves, nonsterile	SB022	pair	5
38	Bleach 10%	SL020	ml	1.5
39	High fidelity hot start Taq polymerase		ul	15
40	PCR buffer		ul	300
41	MgCl2		ul	90
42	F Primer X 30		ul	2
43	R Primer X 30		ul	2
44	dNTPs		ul	60
45	PCR grade water	SL244	ul	2040
46	Ethidium bromide (10 mg/ml)	SL239	ul	10
47	DNA ladder, 100bp		ul	10
48	Loading buffer with dye	SL210	ul	40
49	Agarose ultrapure		g	1.6
50	Agarose NuSieve GTG		g	3.2
51	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	200
52	Masking tape		inch	24
53	96 Capillary array		item	1/200
54	Cycle sequencing kit		ul	480
55	Cycle sequencing purification plates		each	1
56	Optical 96 well reaction plate		each	1
57	Sequencing primers		ul	120
58	0.2 mL strip tubes		each	8
59	0.2 ml PCR tubes		each	31
60	Milli-Q water		ml	35
61	Exonuclease I / Shrimp alkaline phosphatase		ul	60
62	Septa		each	0.3
63	Sequencing cassette		each	1
64	Polymer		ul	30/125
65	Formamide	SL192	ul	900
66	15 mL centrifuge tubes	SL241		2
67	50 mL centrifuge tubes			2
68	2 mL plastic tubes		each	30
69	Running buffer		ul	80
70	0.5 mL microcentrifuge tubes			40
71	Barrier pipet tips1000 uL		ul	7

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81407		
2	Meeting Date: April 2011 Specialty: Pathology <i>Typical Batch Size - 2</i>	<i>Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)</i>		
3		CMS Code	Staff Type	Minutes
72	Barrier pipet tips 200 uL		each	60
73	Barrier pipet tips 20uL		each	420
74	Extraction tubs		each	4
75	Extraction tip assembly		each	1
76				
77	Equipment			
78	Analytical balance		EP004	2
79	Capillary electrophoresis instrument - sequencing			84
80	Capillary electrophoresis sequencing software			84
81	Centrifuge		EP059	3
82	Cooling block			3
83	Gel electrophoresis apparatus with power supply		EP063	30
84	Gel imaging system		EP062	8

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81408		
	Meeting Date: April 2011 Specialty: Pathology	<i>Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)</i>		
2	<i>Typical Batch Size - 2</i>			
3		CMS Code	Staff Type	Minutes
4	Global Period			XXX
5	TOTAL CLINICAL LABOR TIME			199
6		<i>Lab Tech</i>	L033A	18
7		<i>Cytotechnologist</i>	L045A	181
8	TOTAL PRE-SERV CLINICAL LABOR TIME			188
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			
10	TOTAL POST-SERV CLINICAL LABOR TIME			11
11	PRE-SERVICE			
12	Start: When preparing containers/requisitions for physician begins			
13	Confirm orders	L033A	Lab Tech	1
14	Accession specimen, label and prepare specimen for storage until scheduled processing date	L033A	Lab Tech	6
15	DNA Extraction	L045A	Cytotechnologist	4
16	PCR Set-up	L045A	Cytotechnologist	45
17	PCR Gel (L9: 58products)	L045A	Cytotechnologist	25
18	PCR Post Processing 1	L045A	Cytotechnologist	18
19	Post PCR Processing 2	L045A	Cytotechnologist	34
20	Post PCR Processing 3	L045A	Cytotechnologist	13
21	Post PCR Processing 4	L045A	Cytotechnologist	40
22	Review sample and prepare data for physician interpretation	L045A	Cytotechnologist	2
23	End: When specimen is ready for examination by physician			
24	Service Period			
25				
26	Post-Service Period			
27	Start: When specimen examination by physician is complete			
28	Enter results in lab information system after physician interpretation	L033A	Lab Tech	2
29	Prepare, pack and transport specimens and records for in-house storage and external storage	L033A	Lab Tech	2
30	Dispose of remaining specimens, spent chemicals/other consumables, and hazardous waste	L033A	Lab Tech	2
31	Clean Room	L033A	Lab Tech	2
32	Perform station maintenance including system rinse and dry	L033A	Lab Tech	2
33	Perform scheduled data management back-up	L033A	Lab Tech	1
34	End: When specimen, chemical waste and record handling is complete			
35	SUPPLIES		Type of Unit	
36	DNA isolation kit		reaction	1
37	Gown	SB027	item	1
38	Gloves, nonsterile	SB022	pair	5
39	Bleach 10%	SL020	ml	1.5
40	High fidelity hot start Taq polymerase X 58		ul	29
41	PCR buffer		ul	580
42	MgCl2		ul	174
43	F Primer X 58		ul	2
44	R Primer X 58		ul	2
45	dNTPs		ul	116
46	PCR grade water	SL244	ul	3944
47	Ethidium bromide (10 mg/ml)	SL239	ul	15
48	DNA ladder, 100bp		ul	15
49	Loading buffer with dye	SL210	ul	60
50	Agarose ultrapure		g	2.4
51	Agarose NuSieve GTG		g	4.8
52	1X TBE Buffer (Tris, Boric Acid, EDTA)		ml	300
53	Masking tape		inch	36
54	96 Capillary array		item	2/200
55	Cycle sequencing kit		ul	928
56	Cycle sequencing purification plates		each	2
57	Optical 96 well reaction plate		each	2
58	Sequencing primers		ul	232
59	0.2 mL strip tubes		each	15
60	0.2 ml PCR tubes		each	59
61	Milli-Q water		ml	35
62	Exonuclease I / Shrimp alkaline phosphatase		ul	116
63	Septa		each	0.6
64	Sequencing cassette		each	2
65	Polymer		ul	58/125
66	Formamide	SL192	ul	1740
67	15 mL centrifuge tubes	SL241		2
68	50 mL centrifuge tubes			2
69	2 mL plastic tubes		each	58
70	Running buffer		ul	160
71	0.5 mL microcentrifuge tubes			60
72	Barrier pipet tips 1000 uL		ul	15
73	Barrier pipet tips 200 uL		each	130
74	Barrier pipet tips 20uL		each	870

	A	B	C	D
1	AMA Specialty Society RVS Update Committee Recommendation	81408		
	Meeting Date: April 2011 Specialty: Pathology	<i>Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)</i>		
2	<i>Typical Batch Size - 2</i>			
3		CMS Code	Staff Type	Minutes
75	Extraction tubs		each	4
76	Extraction tip assembly		each	1
77				
78	Equipment			Time in Use Minutes
79	Analytical balance		EP004	3
80	Capillary electrophoresis instrument - sequencing			144
81	Capillary electrophoresis sequencing software			144
82	Centrifuge		EP059	3
83	Cooling block			3
84	Gel electrophoresis apparatus with power supply		EP063	45
85	Gel imaging system		EP062	12

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Identified through the Top 9 Harvard Screen

February 2011

Special Stains

The special stains services were identified by the RUC's Relativity Assessment Workgroup through its CMS screen for Harvard-valued codes with utilization greater than 1 million. At the October 2009 RUC Meeting, the RUC recommended that all of the identified codes in this family be surveyed using the standard RUC survey instrument, present an alternative methodology to the Research Subcommittee for review, or present a code change proposal to the CPT Editorial Panel for their review. The College of American Pathologists (CAP) submitted a CPT coding proposal to revise the current descriptors of the special stains services to clarify the appropriate use of these codes. CAP conducted a standard RUC survey for each of the special stains services. The survey data demonstrates that the current work associated with these services is accurate and furthermore supports the specialty society's recommendation that there is no compelling evidence to change the current work of these services. However, as 88318 is being deleted and the utilization is shifting to another code, 88313, which has a lower work RVU, and the RUC understands that these recommendations will represent a work savings.

88312 *Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)*

The RUC reviewed the survey data for 88312. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that although the surveyed code has slightly more intra-service time as compared to the reference code, 24 minutes and 20 minutes, respectively, the reference code is a more intense service to perform as the survey respondents indicated in all of the intensity/complexity measures. Although the survey median for this service was 0.73 work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.54 work RVUs. **Therefore, the RUC recommends a work RVU of 0.54 for CPT code 88312.**

88313 *Special stain including interpretation and report; Group II, all other, (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry*

The RUC reviewed the survey data for 88313. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 89060 *Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)* (Work RVU=0.37). The RUC noted that the surveyed code has slightly more intra-service time as compared to the reference code, 13 minutes and 10 minutes, respectively. Further, the surveyed code is a more intense service to perform as the survey respondents indicated in all of the intensity/complexity measures. The RUC also compared the surveyed code to another reference code 77083 *Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites* (Work RVU=0.20). The RUC noted that the surveyed code has more intra-service time in comparison to this reference code, 13 minutes and 10 minutes, respectively. Although the survey median for this service was 0.56 work RVUs, the specialty society recommended and the RUC agreed that there was no

compelling evidence to change the current value for this service, 0.24 work RVUs. **Therefore, the RUC recommends a work RVU of 0.24 for CPT code 88313.**

88314 Special stain including interpretation and report; histochemical stain on frozen tissue block

The RUC reviewed the survey data for 88314. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that the surveyed code has less intra-service time as compared to the reference code, 13 minutes and 20 minutes, respectively. Further, the reference code requires more mental effort and judgment, technical skill and overall is a more intense service to perform in comparison to the surveyed code as indicated by the survey respondents. The surveyed 25th percentile for this service was 0.45 Work RVUs, which is the current work RVU. Based on these magnitude estimation comparisons and the specialty society recommendation that there was no compelling evidence to change the current value for this service, the RUC recommends maintaining the current value of this service. **The RUC recommends a work RVU of 0.45 for CPT code 88314.**

88319 Special stain including interpretation and report; Group III, for enzyme constituents

The RUC reviewed the survey data for 88319. The specialty society recommended and the RUC agreed that the surveyed time accurately reflects the service being performed. The RUC reviewed the surveyed code in comparison to 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (Work RVU=0.73). The RUC noted that the surveyed code has slightly less intra-service time as compared to the reference code, 18 minutes and 20 minutes, respectively. Further, the reference code requires more mental effort and judgment, psychological stress and overall is a more intense service to perform in comparison to the surveyed code as indicated by the survey respondents. Although the survey median for this service was 0.75 work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.53 work RVUs. **Therefore, the RUC recommends a work RVU of 0.53 for CPT code 88319.**

Practice Expense Inputs:

After the specialty society made several modifications, the RUC approved the clinical labor, supplies and equipment associated with special stains services.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
▲88312	C1	Special stains including interpretation and report; Group I for microorganisms (eg, Gridley, acid fast, methenamine silver), including interpretation and report, each (Report one unit of 88312 for each special stain, on each surgical pathology	XXX	0.54 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
		<u>block, cytologic specimen, or hematologic smear)</u>		
▲88313	C2	<p>Group II, all other, (eg, iron, trichrome), except <u>stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry immunoperoxidase</u>stains, including interpretation and report, each</p> <p><u>(Report one unit of 88313 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear)</u></p> <p>(For immunocytochemistry and <u>immunohistochemistry immunoperoxidase tissue studies</u>, use 88342)</p>	XXX	0.24 (No Change)
+▲88314	C3	<p>histochemical staining <u>on with frozen tissue block, section(s), including interpretation and report</u>-(List separately in addition to code for primary procedure)</p> <p>(Use 88314 in conjunction with <u>17311-17315, 88302-88309, 88331-88332</u>)</p> <p>(Do not report 88314 in conjunction with 17311-17315 for routine frozen section stain [eg, hematoxylin and eosin, toluidine blue], performed during Mohs surgery. When a non-routine histochemical stain on frozen tissue <u>during Mohs surgery</u> is utilized, report 88314 with modifier 59)</p> <p><u>(Report one unit of 88314 for each stain on each frozen surgical pathology block)</u></p> <p><u>(For a special stain performed on frozen tissue section material to identify enzyme constituents, use 88319)</u></p>	ZZZ	0.45 (No Change)
D 88318		Determinative histochemistry to identify chemical components (eg, copper, zinc)	XXX	N/A

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommenda- tion
		<p><u>(88318 has been deleted)</u></p> <p><u>(For determinative histochemistry to identify chemical components, use 88313)</u></p>		
▲88319	C4	<p><u>Group III, for Determinative histochemistry or cytochemistry to identify enzyme constituents, each</u></p> <p><u>(For each stain on each surgical pathology block, cytologic specimen, or hematologic smear, use one unit of 88319)</u></p> <p><u>(For detection of enzyme constituents by immunohistochemical or immunocytochemical technique, use 88342)</u></p>	XXX	0.53 (No Change)

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

CPT Code:88312 Tracking Number
Global Period: XXX

Specialty Society Recommended RVU: **0.54**
RUC Recommended RVU: **0.54**

CPT Descriptor: Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)

(Report one unit of 88312 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Microscopic examination of a Warthin Starry stain performed on stomach biopsy with gastritis obtained from a 70-year-old male.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist performs microscopic examination of the positive control for appropriately stained microorganisms to verify that the appropriate structures are stained. The patient sample is then microscopically examined. The pathologist examines for the presence of any microscopic organisms and interprets them morphologically. The findings are correlated with clinical history, previous tissue samples and laboratory tests. The pathologist composes and dictates the report. The report is edited and signed with the results communicated to appropriate caregivers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2010					
Presenter(s):	Jonathan L. Myles, MD, FCAP					
Specialty(s):	College of American Pathologists					
CPT Code:	88312					
Sample Size:	2500	Resp N:	108	Response:	4.3 %	
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		10.00	58.00	178.00	400.00	1100.00
Survey RVW:		0.30	0.52	0.73	0.86	1.25
Pre-Service Evaluation Time:				0.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		5.00	20.00	24.00	25.00	35.00
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			
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	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (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:	88312	Recommended Physician Work RVU: 0.54			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		24.00			
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		
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

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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88334	XXX	0.73	RUC Time

CPT Descriptor Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	19,660,131

CPT Descriptor 1 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.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11056	000	0.61	Other	1,687,654

CPT Descriptor 2 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 44 % of respondents: 40.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 88312	<u>Key Reference CPT Code:</u> 88334	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	24.00	20.00	
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 Total Time	24.00	20.00	

Other time if appropriate		
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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	3.34	4.16
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.27	3.64
--	------	------

Urgency of medical decision making	3.34	4.25
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.73	4.23
--------------------------	------	------

Physical effort required	3.07	3.16
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.52	4.18
---	------	------

Outcome depends on the skill and judgment of physician	3.95	4.23
--	------	------

Estimated risk of malpractice suit with poor outcome	3.39	3.98
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
----------------------------------	------	------

Intra-Service intensity/complexity	3.36	3.73
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
-----------------------------------	------	------

Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

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	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,326,652 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 2009 Utilization

Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
-----------	-------------	-------------------

Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88312

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

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

CPT Code:88313 Tracking Number
Global Period: XXX

Specialty Society Recommended RVU: **0.24**
RUC Recommended RVU: **0.24**

CPT Descriptor: Special stain including interpretation and report; Group II, all other, (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry

(Report one unit of 88313 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear)

(For immunocytochemistry and immunohistochemistry, use 88342)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Microscopic examination of a Congo red stain performed on a bone marrow biopsy from a 75-year-old male with monoclonal gammopathy

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist examines control tissue known to contain amyloid deposits using both nonpolarized and polarized light microscopy to determine the presence of congophilic apple green birefringent material and that the appropriate structures are stained. The pathologist then examines the patient's sample using both nonpolarized and polarized light microscopy. The pathologist interprets the staining pattern and determines its significance in its histologic location. The findings are correlated with clinical history, previous tissue samples and laboratory tests. The pathologist composes and dictates the report. The report is edited and signed with the results communicated to appropriate caregivers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	88313				
Sample Size:	2500	Resp N:	70	Response: 2.8 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		10.00	20.00	150.00	300.00
Survey RVW:		0.30	0.34	0.56	0.73
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	10.00	13.00	15.00
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		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (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:	88313	Recommended Physician Work RVU: 0.24			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		13.00			
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		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
89060	XXX	0.37	RUC Time

CPT Descriptor Crystal identification by light microscopy with or without polarizing lens analysis, tissue or any body fluid (except urine)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99211	XXX	0.18	RUC Time	8,696,065

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.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 25 % of respondents: 35.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 88313	<u>Key Reference CPT Code:</u> <u>89060</u>	<u>Source of Time</u> <u>RUC Time</u>
Median Pre-Service Time	0.00	3.00	
Median Intra-Service Time	13.00	10.00	
Median Immediate Post-service Time	0.00	3.00	
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 Total Time	13.00	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	3.04	2.36
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.04	2.40
--	------	------

Urgency of medical decision making	2.68	2.32
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.24	2.64
--------------------------	------	------

Physical effort required	2.52	2.28
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.00	2.24
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Outcome depends on the skill and judgment of physician	3.44	2.80
--	------	------

Estimated risk of malpractice suit with poor outcome	2.84	2.12
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	3.04	2.72
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Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The expert panel recommends the current RVW value of 0.24

Specialty	Frequency 0	Percentage 0.00 %
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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? 1,273,054 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 2009 Utilization

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)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88313

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

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

CPT Code:88314 Tracking Number Specialty Society Recommended RVU: **0.45**

Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)

(Use 88314 in conjunction with 17311-17315, 88302-88309, 88331-88332)

(Do not report 88314 in conjunction with 17311-17315 for routine frozen section stain [eg, hematoxylin and eosin, toluidine blue], performed during Mohs surgery. When a non-routine histochemical stain on frozen tissue during Mohs surgery is utilized, report 88314 with modifier 59)

(Report one unit of 88314 for each stain on each frozen surgical pathology block)

(For a special stain performed on frozen tissue section material to identify enzyme constituents, use 88319)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Microscopic examination of an Oil Red O stain performed on a frozen skeletal muscle biopsy in a 30-year-old male with muscular dystrophy

Percentage of Survey Respondents who found Vignette to be Typical: 71%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: N/A

Description of Intra-Service Work: An oil red O stain is performed on frozen tissue sections from the control and patient sample. The pathologist examines control tissue known to contain oil red O positive lipids to verify that the appropriate structures are stained. The pathologist then examines the patient's sample to determine the presence and pattern of Oil red O staining. The pathologist interprets the staining pattern and determines its significance in its histologic location. The findings are correlated with clinical history, previous tissue samples and laboratory tests. The pathologist composes and dictates the report. The report is edited and signed with the results communicated to appropriate caregivers.

Description of Post-Service Work: N/A

CPT Code: 88314

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	88314				
Sample Size:	2500	Resp N:	37	Response:	1.4 %
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		5.00	15.00	20.00	50.00
Survey RVW:		0.20	0.45	0.71	0.75
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	12.00	13.00	15.00
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		
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

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (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:	88314	Recommended Physician Work RVU: 0.45			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		13.00			
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		
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

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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88334	XXX	0.73	RUC Time

CPT Descriptor Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94060	XXX	0.31	RUC Time	1,231,072
<u>CPT Descriptor 1</u> Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95900	XXX	0.42	RUC Time	1,371,085

CPT Descriptor 2 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 17 % of respondents: 45.9 %

TIME ESTIMATES (Median)

	CPT Code: 88314	Key Reference CPT Code: 88334	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	13.00	20.00	
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 Total Time	13.00	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	3.41	3.53
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.35	3.24
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Urgency of medical decision making	3.47	3.76
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.82	3.94
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Physical effort required	3.12	3.06
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.24	3.35
---	------	------

Outcome depends on the skill and judgment of physician	3.94	3.88
--	------	------

Estimated risk of malpractice suit with poor outcome	3.18	3.65
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	3.47	3.65
------------------------------------	------	------

Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

The expert panel recommends the current RVW value of 0.45

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 %
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
22,138 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 2009 Utilization

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88314

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

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

CPT Code:88319 Tracking Number Specialty Society Recommended RVU: **0.53**

Global Period: XXX RUC Recommended RVU: **0.53**

CPT Descriptor: Special stain including interpretation and report; Group III, for enzyme constituents

(For each stain on each surgical pathology block, cytologic specimen, or hematologic smear, use one unit of 88319)

(For detection of enzyme constituents by immunohistochemical or immunocytochemical technique, use 88342)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Microscopic examination of a Nicotinamide adenosine dinucleotide-tetrazolium reductase (NADH-TR) stained slide performed on a skeletal muscle biopsy in a 30-year old-male with muscular dystrophy.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The pathologist examines control tissue known to contain NADH-TR positive muscle fibers to verify that the appropriate structures are stained. The pathologist then examines the patient's sample to determine the presence and pattern of NADH-TR staining. The pathologist interprets the staining pattern and determines its significance in its histologic location. The findings are correlated with clinical history, previous tissue samples and laboratory tests. The pathologist composes and dictates the report. The report is edited and signed with the results communicated to appropriate caregivers.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2010				
Presenter(s):	Jonathan L. Myles, MD, FCAP				
Specialty(s):	College of American Pathologists				
CPT Code:	88319				
Sample Size:	2500	Resp N:	31	Response: 1.2 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		10.00	38.00	75.00	150.00
Survey RVW:		0.30	0.73	0.75	1.00
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		5.00	15.00	18.00	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 0.00	99239x 0.00		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 0.00

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (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:	88319	Recommended Physician Work RVU: 0.53			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		18.00			
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		
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 0.00	57x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
88334	XXX	0.73	RUC Time

CPT Descriptor Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	19,660,131

CPT Descriptor 1 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.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11056	000	0.61	Other	1,687,654

CPT Descriptor 2 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); 2 to 4 lesions

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 13 **% of respondents:** 41.9 %

TIME ESTIMATES (Median)

	CPT Code: 88319	Key Reference CPT Code: 88334	Source of Time RUC Time
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	18.00	20.00	
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 Total Time	18.00	20.00	

Other time if appropriate		
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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	3.77	3.85
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.85	3.69
--	------	------

Urgency of medical decision making	3.31	3.92
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.00	3.77
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Physical effort required	3.31	3.31
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.31	3.77
---	------	------

Outcome depends on the skill and judgment of physician	3.85	3.92
--	------	------

Estimated risk of malpractice suit with poor outcome	3.15	3.77
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	0.00	0.00
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Intra-Service intensity/complexity	3.77	3.77
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Post-Service intensity/complexity	0.00	0.00
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Additional Rationale and Comments

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

Following the survey, the data were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

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	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
17,584 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 2009 Utilization

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
-----------	-----------	------------	---

Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 88319

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

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

CPT Long Descriptor: Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)

(Report one unit of 88312 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The practice expense inputs were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice settings.

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

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Accession special stain order in laboratory information system
 Pull and verify tissue block and control block
 Cut block on microtome and place tissue on microscopic slide
 Cut control tissue on microtome and place tissue on microscopic slide
 De-paraffinize in xylene and rehydrate slides in progressive alcohols to water - place in distilled water
 Prepare uranyl nitrate and sensitize slides in uranyl nitrate solution. Microwave 1 min
 Rinse slides in distilled water
 Prepare 1% silver nitrate. Place slides in 1% silver nitrate and heat in microwave 1 min. Stand in hot silver nitrate for 3 min
 Rinse in 3 changes distilled water
 Rinse in 2 changes 95% alcohol
 Rinse in 2 changes 100% alcohol
 Prepare gum mastic and hydroquinone and filter. Place slide in solution for 5 min
 Rinse in 3 changes distilled water
 Prepare reducing solution and place slides in solution in microwave 20 sec
 Place warm reducing solution in warm waterbath. Place slide in solution. Set timer for 4 min
 Rinse in distilled water. Check slides every min for correct staining. Return to solution if not correct
 Rinse in 100% alcohol
 Dehydrate to xylene through progressive alcohols
 Load slides on automatic coverslipper
 Review positive control slide
 Label slides, collate paperwork and deliver to physician

Intra-Service Clinical Labor Activities: None

Post-Service Clinical Labor Activities:

Re-file block
 Clean equipment and workstation in accession area
 Clean equipment and workstation in histology lab
 Load solvent in recycle system
 File slides

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

CPT Long Descriptor: Special stain including interpretation and report; Group II, all other, (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry

(Report one unit of 88313 for each special stain, on each surgical pathology block, cytologic specimen, or hematologic smear)

(For immunocytochemistry and immunohistochemistry, use 88342)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The practice expense inputs were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice 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: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Accession special stain order in laboratory information system

Pull and verify tissue block and control block

Cut block on microtome and place tissue on microscopic slide

Identify purchased positive control slide

De-paraffinize in xylene and rehydrate slides in progressive alcohols to water - place in distilled water

Stain in Congo Red 1 hour

Rinse in 3 changes distilled water

Prepare alkaline alcohol and differentiate 3 sec

Wash in running water 5 min

Counterstain 3 min

Rinse in 3 changes distilled water

Prepare acid alcohol and decolorize 15 sec

Rinse in 3 changes distilled water

Prepare ammonia water and blue for 15 sec

Rinse in 2 changes distilled water

Dehydrate to xylene through progressive alcohols

Load slides on automatic coverslipper

Review positive control slide

Label slides, collate paperwork and deliver to physician

Intra-Service Clinical Labor Activities: None

Post-Service Clinical Labor Activities:

Re-file block

Clean equipment and workstation in accession area

Clean equipment and workstation in histology lab

Load solvent in recycle system

File slides

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

CPT Long Descriptor: Special stain including interpretation and report; histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)

(Use 88314 in conjunction with 17311-17315, 88302-88309, 88331-88332)

(Do not report 88314 in conjunction with 17311-17315 for routine frozen section stain [eg, hematoxylin and eosin, toluidine blue], performed during Mohs surgery. When a non-routine histochemical stain on frozen tissue during Mohs surgery is utilized, report 88314 with modifier 59)

(Report one unit of 88314 for each stain on each frozen surgical pathology block)

(For a special stain performed on frozen tissue section material to identify enzyme constituents, use 88319)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The practice expense inputs were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice 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: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Accession special stain order in laboratory information system
Mount fresh tissue on chuck and freeze in isopentane and liquid nitrogen
Cut frozen block on cryostat and place tissue on microscopic slides for sectioning
Prepare solutions: 60% isopropyl alcohol, 0.5% ORO solution (in isopropyl alcohol)
Prepare working solution, let stand, and filter twice
Incubate in working solution
Counterstain in hematoxylin and "blue" in ammonia water
Coverslip by hand
Review positive control slide
Label slides, collate paperwork and deliver to physician

Intra-Service Clinical Labor Activities:

None

Post-Service Clinical Labor Activities:

Prepare frozen block for storage in freezer
Clean equipment and workstation in accession area
Clean equipment and workstation in histology lab
File slides

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

CPT Long Descriptor: Special stain including interpretation and report; Group III, for enzyme constituents

(For each stain on each surgical pathology block, cytologic specimen, or hematologic smear, use one unit of 88319)

(For detection of enzyme constituents by immunohistochemical or immunocytochemical technique, use 88342)

Global Period: XXX

Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The practice expense inputs were reviewed by an expert panel that included CAP's relative value workgroup, CAP's RUC advisor, the American Society of Cytopathology (ASC) RUC advisor and representatives from the general and academic pathology practice 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: N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Accession special stain order in laboratory information system
Mount fresh tissue on chuck and freeze in isopentane and liquid nitrogen
Cut frozen block on cryostat and place tissue on microscopic slides for sectioning
Prepare and dispense monobasic and dibasic phosphate buffers
Prepare and dispense 30%, 60%, 90% and 100% acetone solutions
Preparation of incubation media
Incubate slides with NADH solution, rinse with 30/60/90%
Dehydrate to xylene through progressive alcohols
Coverslip by hand
Review positive control slide
Label slides, collate paperwork and deliver to physician

Intra-Service Clinical Labor Activities: None

None

Post-Service Clinical Labor Activities:

Prepare frozen block for storage in freezer
Clean equipment and workstation in accession area
Clean equipment and workstation in histology lab
Load solvent in recycle system
File slides

	A	B	C	D	E	F	G	H	I	J	K
1	AMA/Specialty Society RVS Update Committee Recommendation			88312 Manual		88313 Manual		88314		88319	
2	Meeting Date: February 2011			Special stain including interpretation and report; Group I for microorganisms (eg, acid fast, methenamine silver)		Special stain including interpretation and report; Group II, all other, (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry		Special stain including interpretation and report; histochemical stain on frozen tissue block		Special stain including interpretation and report; Group III, for enzyme constituents	
		CMS	Staff								
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD XXX										
5	TOTAL CLINICAL LABOR TIME			50.0		46.0		53.0		70.0	
6	TOTAL PRE-SERV CLINICAL LABOR TIME			43.0		39.0		42.0		58.0	
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0		0.0		0.0		0.0	
8	TOTAL POST-SERV CLINICAL LABOR TIME			7.0		7.0		11.0		12.0	
9	PRE-SERVICE										
10	Start: When preparing containers/requisitions for physician begins										
11	Accession special stain order in laboratory information system	L033A	Lab Tech	1		1		1		1	
12	Pull and verify tissue block and control block	L037B	Histotech	1		1					
13	Cut block on microtome and place tissue on microscopic slide	L037B	Histotech	10		10					
14	Cut control tissue on microtome and place tissue on microscopic slide	L037B	Histotech	2							
15	Identify purchased positive control slide	L037B	Histotech			1		1			
16	De-paraffinize in xylene and rehydrate slides in progressive alcohols to water - place in distilled water	L037B	Histotech	2		2					
17	Prepare uranyl nitrate and sensitize slides in uranyl nitrate solution. Microwave 1 min	L037B	Histotech	5							
18	Rinse slides in distilled water	L037B	Histotech	1							
19	Prepare 1% silver nitrate. Place slides in 1% silver nitrate and heat in microwave 1 min. Stand in hot silver nitrate for 3 min	L037B	Histotech	2							
20	Stain in Congo Red 1 hour	L037B	Histotech			1					
21	Rinse in 3 changes distilled water	L037B	Histotech	1		1					
22	Rinse in 2 changes 95% alcohol	L037B	Histotech	0							
23	Rinse in 2 changes 100% alcohol	L037B	Histotech	0							
24	Prepare gum mastic and hydroquinone and filter. Place slide in solution for 5 min	L037B	Histotech	5							
25	Prepare alkaline alcohol and differentiate 3 sec	L037B	Histotech			5					
26	Wash in running water 5 min	L037B	Histotech			1					
27	Counterstain 3 min	L037B	Histotech			1					
28	Rinse in 3 changes distilled water	L037B	Histotech			1					
29	Prepare acid alcohol and decolorize 15 sec	L037B	Histotech			5					
30	Rinse in 3 changes distilled water	L037B	Histotech			1					
31	Prepare ammonia water and blue for 15 sec	L037B	Histotech			3					
32	Rinse in 2 changes distilled water	L037B	Histotech	1		1					
33	Prepare reducing solution and place slides in solution in microwave 20 sec	L037B	Histotech	2							
34	Place warm reducing solution in warm waterbath. Place slide in solution. Set timer for 4 min	L037B	Histotech	0							
35	Rinse in distilled water. Check slides every min for correct staining. Return to solution if not correct	L037B	Histotech	6							
36	Rinse in 100% alcohol	L037B	Histotech	0							
37	Mount fresh tissue on chuck and freeze in isopentane and liquid nitrogen	L037B	Histotech					3		3	
38	Cut frozen block on cryostat and place tissue on microscopic slides for sectioning	L037B	Histotech					10		10	
39	Prepare solutions: 60% isopropyl alcohol, 0.5% ORO solution (in isopropyl alcohol)	L037B	Histotech					10			
40	Prepare and dispense monobasic and dibasic phosphate buffers	L037B	Histotech							6	
41	Prepare and dispense 30%, 60% , 90% and 100% acetone solutions	L037B	Histotech							10	
42	Prepare working solution, let stand, and filter twice	L037B	Histotech					10			
43	Preparation of incubation media	L037B	Histotech							5	
44	Incubate in working solution	L037B	Histotech					1			
45	Incubate slides with NADH solution, rinse with 30/60/90%	L037B	Histotech							18	
46	Counterstain in hematoxylin and "blue" in ammonia water	L037B	Histotech					2			
47	Dehydrate to xylene through progressive alcohols	L037B	Histotech	1		1				1	
48	Coverslip by hand	L037B	Histotech					2		2	
49	Load slides on automatic coverslipper	L037B	Histotech	1		1					
50	Review positive control slide	L037B	Histotech	1		1		1		1	
51	Label slides, collate paperwork and deliver to physician	L037B	Histotech	1		1		1		1	
52	End: When specimen is ready for examination by physician										
53	Service Period										
54				None							
55	Post-Service Period										

	A	B	C	D	E	F	G	H	I	J	K
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		CMS	Staff								
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
56	Start: When specimen examination by physician is complete										
57	Refile block	L033A	Lab Tech	1		1					
58	Prepare frozen block for storage in freezer	L033A	Lab Tech					1		1	
59	Clean equipment and workstation in accession area	L033A	Lab Tech	0		0		5		5	
60	Clean equipment and workstation in histology lab	L033A	Lab Tech	4		4		4		4	
61	Load solvent in recycle system	L033A	Lab Tech	1		1				1	
62	File slides	L033A	Lab Tech	1		1		1		1	
63	End: When specimen, chemical waste and record handling is complete										
64	SUPPLIES										
			Unit								
65	positive control block/slide	SL112	item	1		1		1			
66	slide, microscope	SL122	item	2		1					
67	label for slides	SL085	item	2		2		2		1	
68	eye shield,non-fog	SG049	item	1		1		1		1	
69	gloves,nonsterile,nitrile	SB023	pair	3		3		3		3	
70	gown, impervious, staff	SB027	item	1		1		1		1	
71	blade, microtome	SF004	item	1		1		1		1	
72	mask, surgical	SB033	item	1		1		1		1	
73	gauze, 4x4	SG051	item	5		4		2		1	
74	kimwipe	SM037	item	2		1					
75	disposable spatula	SL130	item	4		1					
76	coverslip, glass	SL030	item	2		2		2		1	
77	filter paper, qualitative, 18.5cm	SL065	item	1		1		1			
78	distilled water	SK087	oz	205ml		70ml					
79	uranyl nitrate		gm	0.5 gms							
80	hydroquinone		gm	0.5 gms							
81	gum mastic		gm	1.25 gms							
82	silver nitrate		gm	0.52 gms							
83	xylene solution	SL151	ml	50 ml		50 ml				30ml	
84	ethanol 100%	SL189	ml	255ml		235ml		125ml		160ml	
85	counterstain (neutral red soln)	SL029	ml			0					
86	Congo Red					25ml					
87	sodium hydroxide	SL128	gm			1 gm					
88	Harris hematoxin reagent, filtered	SL077	ml			25 ml		25ml			
89	ammonium hydroxide					.5ml		.5ml			
90	HCl, 1% hydrochloric acid	SL229	ml			0.25 ml					
91	bleach	SL020	ml	30ml		30ml		30ml		30 ml	
92	insulated gloves for handling liquid nitrogen		pair					0		0	
93	safety glasses for liquid nitrogen	SB038	item					0		0	
94	NADH		ml							3mg	
95	acetone	SL001								112ml	
96	transfer pipettes 23 ml	SL109	item			1		1		3	
97	Nitro blue tetrazolium		ml							.2ml	
98	phosphate buffer, monobasic	SL105	ml							15ml	
99	phosphate buffer, dibasic	SL104	ml							85ml	
100	.9% sodium chloride		ml							1.1ml	
101	liquid nitrogen,	SD082	ml					500ml		400ml	
102	10% Gum Tragacanth/OCT		ml					2ml		2ml	
103	aqueous mounting media (Histomount)	SL095	ml					.5ml		.5ml	
104	isopentane	SL091	ml					5ml		5ml	
105	cork disc (5 mm thick 15 mm diameter)		item					1			
106	Oil Red O		mg					.25mg			
107	syringe filter		item					1			
108	weighing boat		item	1		1		1		1	
109	slide, microscope, coated	SL183	item					2		1	
110	Equipment										
111	waterbath	EP043		7		5					
112	microtome	ER041		12		10					
113	hood, fume	EP017		6		11		5		20	
114	solvent recycler system	EP038		12		12				7	
115	robotic coverslipper	EP033		2		2				0	
116	compound microscope	EP024		15		8		8		11	
117	slide etcher/labeler	EP025		1		1		1		1	
118	slide dryer	EP034		12		12				12	
119	balance, analytic	EP004		5				2		5	
120	pH conductivity meter	EP030								2	

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3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
121	cryostat	EQ092						15		15	
122	isotemp, oven	EP049						60			

AMA/Specialty Society RVS Update Committee Summary of Recommendations

February 2011

Transcranial Magnetic Stimulation

In February 2010, the CPT Editorial Panel converted two Category III codes, 0160T and 0161T, to Category I status to report treatment planning and treatment delivery/management of transcranial magnetic stimulation. In October 2010, the CPT Editorial Panel modified the two existing CPT codes to clarify that 90867 should be used to report the initial TMS treatment including cortical mapping, motor threshold determination and delivery/management and that 90868 should be used to report subsequent delivery and management of TMS session. Further, the CPT Editorial Panel created a third Category I code to report redetermination of motor threshold during a course of transcranial magnetic stimulation therapy.

90867 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management

The RUC reviewed the survey results from 76 psychiatrists who frequently perform this service. The specialty society convened an expert panel to review the survey data and determined that the surveyed times were inappropriate as they did not reflect the administration of this service. The specialty society recommended that the pre-service time for this service should be derived from pre-service time package 5, which has 7 minutes of evaluation time. The specialty recommended an additional 15 minutes of pre-service time for positioning as precise positioning of the head is critical for this treatment to be successful. The expert panel agreed that 65 minutes of intra-service time, to perform the cortical mapping, motor threshold determination and treatment delivery, and 10 minutes of post-service time was reflective of the service and was derived from the survey data. The RUC agreed that the modified service times presented by the specialty accurately reflected the service provided. The RUC compared the surveyed code to reference code, 95978 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour* (work RVU=3.50). The RUC noted that although the survey respondents indicated that the surveyed code was a more intense service to perform, the surveyed code and 95978 have similar intra-service times, 65 minutes and 60 minutes, respectively. Based on this comparison, the RUC agreed with the specialty society recommended work RVU of 3.52, the survey median. **The RUC recommends a work RVU of 3.52 for CPT code 90867.**

90868 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session

The RUC reviewed the survey data for 90868 and agreed with the specialty society that the survey respondents over-estimated the service times and work RVUs associated with this procedure. Therefore, the specialty society recommended that the work RVUs and times for this procedure should be crosswalked to 99212 *Office or other outpatient visit for the evaluation and management of an established patient, (work RVU=0.48, pre-service= 2 minutes, intra-service= 10 minutes, post service= 4 minutes)*. The specialty society agrees that these times and work RVUs are appropriate for the procedure being provided. **The RUC agrees with the specialty society and recommends a work RVU of 0.48 for CPT code 90868.**

90869 Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

The RUC reviewed the survey results from 67 psychiatrists who frequently perform this service. The specialty society convened an expert panel to review the survey data and determined that the surveyed times were inappropriate as they did not reflect the administration of this service. The specialty society recommended that the pre-service time for this service should be derived from pre-service time package 5, which has 7 minutes of evaluation time. The specialty recommended an additional 10 minutes of pre-service time for positioning as precise positioning of the head is critical for this treatment to be successful. Further, the specialty society's expert panel agreed that the time required to perform the cortical mapping, motor threshold re-determination and treatment delivery was 45 minutes. Therefore, the specialty society recommends 45 minutes for intra-service time. The specialty society agreed that 10 minutes of post-service time was reflective of the service and was derived from the survey data. The RUC agreed that the modified service times presented by the specialty accurately reflected the service provided. The RUC compared the surveyed code to two reference codes, 95978 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour* (work RVU=3.50) and 99205 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU=3.17). The RUC noted that although the survey respondents indicated that the surveyed code is a more intense service to perform in comparison to the reference code, the surveyed code has less intra-service time as compared to 95978, 45 minutes and 60 minutes, respectively. Further, the RUC noted that the surveyed code and 99205 have the same intra-service time, 45 minutes. Based on these comparisons, the RUC agreed with the specialty society recommended work RVU of 3.20, the survey median. **The RUC recommends a work RVU of 3.20 for CPT code 90869.**

New Technology: The specialty society requests and the RUC agrees that these three codes should be added to the new technology list.

Practice Expense: The RUC modified the clinical labor time specifically the assist physician time to reflect the modified intra-service times as stated above. The RUC approved the modified practice expense inputs.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
(For analysis/programming of neurostimulators used for vagus nerve stimulation therapy, see 95970, 95974,95975)				
▲90867	N1	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; <u>initial, planning including cortical mapping, motor threshold determination, delivery and management</u> (Report only once per course of treatment) (Do not report 90867 in conjunction with 95928, 95929, <u>90868, 90869</u>)	000	3.52
▲90868	N2	<u>subsequent</u> delivery and management, per session	000	0.48
●90869	N3	subsequent motor threshold re-determination with delivery and management <u>(Do not report 90869 in conjunction with 90867, 90868)</u> <u>(If a significant, separately identifiable Evaluation and Management, medication management, psychotherapy or psychotherapy with evaluation and management service is performed, the appropriate E/M, psychotherapy, psychotherapy with E/M service or 90862 may be reported in addition to 90867-90869. Evaluation and management activities directly related to cortical mapping, motor threshold determination, delivery and management of TMS are not separately reported.)</u>	000	3.20

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

CPT Code:90867 Tracking Number N1 Original Specialty Recommended RVU: **3.86**
Presented Recommended RVU: **3.52**
Global Period: 000 RUC Recommended RVU: **3.52**

CPT Descriptor: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, planning including cortical mapping, motor threshold determination, delivery and management

(Report only once per course of treatment)

(Do not report 90867 in conjunction with 95928, 95929, 90868, 9086XX)

(If a significant, separately identifiable Evaluation and Management, medication management, psychotherapy or psychotherapy with evaluation and management service is performed, the appropriate E/M, psychotherapy, psychotherapy with E/M service or 90862 may be reported using modifier 25 in addition to 90867-9086XX. Evaluation and management activities directly related to delivery of TMS are not separately reported.)

(Psychotherapy with or without E/M or medication management services unrelated to the delivery of TMS may be reported separately.)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female presents with a clinical diagnosis consistent with DSM-IV defined Major Depressive Disorder, severe, with a recurrent course of illness. She has a secondary diagnosis of generalized anxiety disorder, and has experienced a recurrent course of depressive illness, with at least 3 prior episodes of major depression. Her history in the present episode is also significant for failure to receive benefit from treatment with three separate antidepressant medication trials, from two different chemical classes. She has also been treated with a combination of an antidepressant and an atypical antipsychotic medication, which she discontinued because of significant weight gain. The patient is to be treated with Transcranial Magnetic Stimulation (TMS) therapy.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 2%

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? 7%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Reviews the medical history including any potential increased risk for a seizure (e.g. history of head injury or past seizure, medications that could lower the seizure threshold) or potential risks associated with

exposure to a magnetic field (e.g. implanted medical devices). In planning the TMS treatment consider patient characteristics to decide on the type of TMS to provide with respect to treatment site, frequency and intensity.

Description of Intra-Service Work: The physician performs a brief focused interview to determine patient's mental status and ability to proceed with the procedure. Confirms with the patient: identity, current medications, and any significant clinical changes. Discusses the risks and benefits, and alternate treatment options with the patient and obtains written consent. The physician responds to any patient questions.

Positioning the Patient and in particular positioning the Pt's head precisely by -- centering the head in the head positioner, using the laser attachment to identify the midline, placing the positioning tape to stabilize head, and then locking the contralateral head support in place. The head positioner is adjusted along all 3 axes, and the parameters on each gauge is recorded.

Finding the Target Hand Muscle includes the following -- find the vertex and go laterally 5 cm. Place the coil in the estimated location and use single pulse TMS to search for the target hand muscle. Increase intensity slowly until a muscle twitch is obtained in the hand and use a grid approach to find the target muscle. Once the target muscle contraction is found, then stimulate across the anterior-posterior plane to find the most anterior location and most posterior location that still produces a muscle twitch. Find the midpoint or area of maximal contraction and repeat this process along the medial-lateral plane. Find the cross point between these two planes and use this location to determine motor threshold.

Determining Motor Threshold (MT) -- the MT value is defined as the lowest level of system output power that produces a visible movement in the targeted hand muscle. This is done using a computer program that calculates MT based on yes/no responses for stimulations at various intensities, or by using step-wise increases and decreases in intensity to identify at what intensity a contraction is seen in half of the stimulations.

Determining Treatment Site -- advance 5-6 cm anteriorly from the motor cortex site of the target hand muscle along the superior oblique plane or determine the treatment site using the EEG-F3 method.

Treatment and Clinical Monitoring -- to initiate treatment the physician advances the treatment coil to the targeted treatment location and the prescribed treatment parameters are selected (frequency, intensity, number of stimuli, treatment train length and inter-stimulus interval). The coil must remain in good contact with the patient's head for the duration of treatment. During the treatment session the patient must be closely monitored at all times to ensure good coil-to-head contact to optimize penetration of the electromagnetic pulses to the cortex. The clinician monitors the patient's clinical status for comfort and tolerability and, if necessary, adjusts coil position and customizes the stimulation parameters to mitigate discomfort. Although the risk of a seizure is low (<1%) it is a significant medical complication, thus patients must be monitored for any signs or symptoms that may indicate the emergence of an ictal event, and the physician must be ready to respond if necessary. The physician leaves once it is determined that the treatment is proceeding appropriately.

Description of Post-Service Work: The pertinent information is documented in the patient's medical record. Communicate with other physicians, non-physician clinicians and/or family regarding any clinically relevant information.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011					
Presenter(s):	Jeremy Musher, MD, Patrick Marsh, MD, Shirlene Sampson, MD					
Specialty(s):	Psychiatry					
CPT Code:	90867					
Sample Size:	354	Resp N:	76	Response: 21.4 %		
Sample Type:	Convenience Additional Sample Information:					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		1.00	5.75	15.00	25.00	800.00
Survey RVW:		1.00	3.17	3.52	4.00	10.50
Pre-Service Evaluation Time:				75.00		
Pre-Service Positioning Time:				15.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		15.00	40.00	45.00	60.00	120.00
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			
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); 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:	90867	Recommended Physician Work RVU: 3.52		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		7.00	7.00	0.00
Pre-Service Positioning Time:		15.00	0.00	15.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		65.00		
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 0.0	99239x 0.0	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95978	XXX	3.50	RUC Time

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99223	XXX	3.86	RUC Time	5,805,837

CPT Descriptor 1 Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99328	XXX	4.09	RUC Time

CPT Descriptor Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 18 **% of respondents:** 23.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 90867	<u>Key Reference CPT Code:</u> 95978	<u>Source of Time</u> RUC Time
Median Pre-Service Time	22.00	5.00	
Median Intra-Service Time	65.00	60.00	

Median Immediate Post-service Time	10.00	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	97.00	70.00
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	4.00	3.83
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.11	4.06
Urgency of medical decision making	3.56	3.44

Technical Skill/Physical Effort (Mean)

Technical skill required	4.44	4.06
Physical effort required	3.56	3.06

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.33	3.50
Outcome depends on the skill and judgment of physician	4.06	3.89
Estimated risk of malpractice suit with poor outcome	3.28	3.44

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.17	3.11
Intra-Service intensity/complexity	4.61	4.33
Post-Service intensity/complexity	2.67	2.50

Additional Rationale and Comments

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

We are submitting the following recommendations for code 90867, *Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial planning including cortical mapping, motor threshold determination, delivery and management*: we recommend an RVW of 3.86 and times of 7 minutes pre, 80 minutes intra, and 10 minutes post service for a total time of 97 minutes.

Background/History

Two codes, 0160T, *Therapeutic repetitive transcranial magnetic stimulation treatment planning*, and 0161T, *Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session*, describing therapeutic repetitive transcranial magnetic stimulation procedures were originally developed in 2007 as Category III codes within CPT. A coding change proposal was brought forward at the February 2010 CPT Editorial Panel meeting by the device manufacturer to change the status of these codes from Category III to Category I. The CPT Editorial Panel approved the request, creating two Category I codes that replicated the original Category III codes: 90867 described the initial planning session, which included the cortical mapping and the motor threshold determination; and a second code, 90868, described the stimulation treatment itself. The codes, as originally constructed, were forwarded to the RUC for review in April 2010.

The codes were pre-facilitated at that April meeting at the request of the society, during which a number of issues were identified, including the reallocation of the time components and the identification of a missing piece of work that was not accurately captured by either of the new codes. The society requested that the two codes be withdrawn from the RUC process until such time as a third code could be developed.

A coding change request proposal for the third code was developed and reviewed by CPT at its October 2010 meeting. The CPT Editorial Panel not only approved the request for the third code 9086XX, *Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management*, it also made revisions to the description of 90867 to more clearly define the work of the initial procedure. Specifically, a stimulation treatment session was included within the work described by a 90867 since the initial planning session is almost always followed by a stimulation treatment. To be clear, the current codes under survey do not have the same descriptions as those surveyed for the April 2010 RUC. The society made efforts to highlight the change in the descriptor of the code for the respondents, but it appears that many of those participating may not have taken this change into account when they completed the most recent survey. The results of that survey and our recommendations are presented within this SOR.

Analysis and Recommendations from the Expert Panel

The APA convened an expert panel to review the results of the survey. In a review of the data for 90867 our experts highlighted a number of items and made several recommendations:

1. Our panel selected pre-service evaluation package 5, *Procedure without sedation/anesthesia care* with a pre-service evaluation of 7 minutes and positioning and scrub, dress and wait time of 0. The experts agreed that the median value for the pre-service evaluation time of 75 minutes (60 minutes for pre-service evaluation on the day prior to treatment and 15 minutes pre-service evaluation on the day of treatment) was excessive, believing that the survey respondents failed to understand the question. They recommended that 60 minutes be removed, reducing the median pre-service evaluation time to 15 minutes. **Following a review of the RUC standards, the panel recommended removing an additional 8 minutes, resulting in the recommendation of a total of 7**

minutes of pre-service evaluation time.

2. Our expert panel made the following recommendations in a review of the responses regarding intra-service time:
 - a. Further review of the responses for pre-service time showed a median of 15 minutes of pre-service positioning time. Our expert panel believes that the survey respondents inappropriately allocated this time to pre-service time rather than to intra-service time. Cortical mapping, which involves a series of movements or repositioning of the device over a defined region of the brain, is a key element of physician work for 90867. According to the experts on our panel, it takes a minimum of 60 minutes to do the cortical mapping and dose determination. The panel agreed that there was clearly some confusion on the part of the survey respondents and **made a recommendation to move the 15 minutes allocated to the category of pre-service positioning time to intra-service time, which increased the median intra-service time to 60 minutes.**
 - b. Survey respondents did not appear to include the time spent administering an actual stimulation treatment within the times allocated to the intra-service work despite our efforts to make them aware of the inclusion of this work in the code. It was the consensus of the expert panel that survey respondents failed to note the change in the work descriptor. When comparing the median times of the previous survey (April 2010) of this code, which at that time did not include a stimulation treatment session, the times at the 25th percentile and median were the same, 40 and 45 minutes (again with time incorrectly allocated to the pre-service for the positioning work). Each stimulation treatment session is done for a minimum of 37.5 minutes. Additional time is typically needed to make adjustments to the dosing or positioning of the magnetic coil because of patient discomfort, especially during the initial treatment session. The experts reported variability in the amount of time physicians are present for the initial stimulation. Some physicians perform the full course of the first treatment to monitor response and make adjustments; others remain for the first half of the treatment, to ensure the patient is tolerating the treatment and it is progressing appropriately. The nurse or technician then remains to complete the full course. **Our expert panel recommended a further increase in the total intra time to 80 minutes --sixty minutes for the cortical mapping and dose determination and 20 minutes to provide a portion of the first treatment, for a total intra-service time of 80 minutes and a total time over all (when adding in pre and post time) of 97 minutes, which the expert panel agreed was appropriate for this service.**
3. In a review of the recommended RVWs, the expert panel concluded that the survey respondents did not appear to factor the stimulation treatment into their estimates for work relative values. The 25th percentile and median RVWs for the current survey were lower than those from the original survey (April 2010), which did not include the treatment. Using magnitude estimation, members of the expert panel compared the work of a 90867 to that of a 99223, *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit,* which has an RVW of 3.86 and times of 15 pre, 55 intra, and 20 post minutes for a total time of 90 minutes. While the total time of the procedure is nearly the same, 97 minutes for 90867 and 90 minutes for 99223, the intra-service time is greater for 90867 (80 minutes intra) than that for 99223 (55 minutes intra). The risk associated with the 90868 is also significant because of the multiple stimulations of the motor cortex, which has the highest risk area for seizure production.

A review of the survey results showed that 22% of the survey respondents selected 99223 as a key reference service, just 1% lower than the most commonly selected code, 95978, *Electronic analysis of implanted*

neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour. Further analysis of these responses showed that survey respondents rated the 90867 higher for the intensity and complexity measures than the 99223 in every area.

Our expert panel recommended an RVW of 3.86, which is equal to that of the 99223.

Conclusion:

For the reasons discussed above, the expert panel **recommends the work RVW of 3.86 with a pre-service time of 7 minutes, an intra-service time of 80 minutes, and a post-service time of 10 minutes for a total time of 97 minutes.**

Medicare Frequency Data:

We would like to request that this be placed on the new technology list for review of the utilization. In a review of the available utilization data we found that 0160T was billed only once. A check of other unlisted services codes produced a total number of psychiatric claims under 30 so and estimate regarding the Medicare frequency data is difficult to develop.

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) 0160T

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 Psychiatry How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Review of available data re new patients in consultation with TMS experts

Specialty Psychiatry	Frequency 5000	Percentage 100.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Review of available data re new patients in consultation with TMS experts

Specialty Psychiatry	Frequency 1	Percentage 100.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Specialty	Frequency 0	Percentage 0.00 %
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Do many physicians perform this service across the United States? No

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

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. 90870, Electroconvulsive Therapy

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

CPT Code:90868 Tracking Number N2

Original Specialty Recommended RVU: **0.76**Presented Recommended RVU: **0.76**

Global Period: 000

RUC Recommended RVU: **0.48**

CPT Descriptor: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session

(If a significant, separately identifiable Evaluation and Management, medication management, psychotherapy or psychotherapy with evaluation and management service is performed, the appropriate E/M, psychotherapy, psychotherapy with E/M service or 90862 may be reported using modifier 25 in addition to 90867-9086XX. Evaluation and management activities directly related to delivery of TMS are not separately reported.)

(Psychotherapy with or without E/M or medication management services unrelated to the delivery of TMS may be reported separately.)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old female presents with a clinical diagnosis consistent with DSM-IV defined Major Depressive Disorder, severe, with a recurrent course of illness. She has a secondary diagnosis of generalized anxiety disorder, and has experienced a recurrent course of depressive illness, with at least 3 prior episodes of major depression. Her history in the present episode is also significant for failure to receive benefit from treatment with three separate antidepressant medication trials, from two different chemical classes. She has also been treated with a combination of an antidepressant and an atypical antipsychotic medication, which she discontinued because of significant weight gain. The patient is to be treated with Transcranial Magnetic Stimulation (TMS) therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 2%

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? 10%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Reviews the medical history including any potential increased risk for a seizure (e.g. history of head injury or past seizure, medications that could lower the seizure threshold) or potential risks associated with exposure to a magnetic field (e.g. implanted medical devices). In planning the TMS treatment consider patient characteristics to decide on the type of TMS to provide with respect to treatment site, frequency and intensity.

Description of Intra-Service Work: The physician performs a brief focused interview to determine patient's mental status and ability to proceed with the procedure. Confirms with the patient: identity, current medications, and any significant clinical changes. The physician responds to any patient questions.

Treatment and Clinical Monitoring -- The physician initiates treatment by advancing the treatment coil to the targeted treatment location and the prescribed treatment parameters are selected (frequency, intensity, number of stimuli, treatment train length and inter-stimulus interval). The coil must remain in good contact with the patient's head for the duration of treatment. During the treatment session the patient must be closely monitored at all times to ensure good coil-to-head contact to optimize penetration of the electromagnetic pulses to the cortex. The clinician monitors the patient's clinical status for comfort and tolerability and, if necessary, adjusts coil position and customizes the stimulation parameters to mitigate discomfort. Although the risk of a seizure is low (<1%) it is a significant medical complication, thus patients must be monitored for any signs or symptoms that may indicate the emergence of an ictal event, and the physician must be ready to respond if necessary. The physician leaves once it is determined that the treatment is proceeding appropriately.

Description of Post-Service Work: The pertinent information is documented in the patient's medical record. Communicate with other physicians, non-physician clinicians and/or family regarding any clinically relevant information.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011				
Presenter(s):	Jeremy Musher, MD, Patrick Marsh, MD, Shirlene Sampson, MD				
Specialty(s):	Psychiatry				
CPT Code:	90868				
Sample Size:	354	Resp N:	69	Response: 19.4 %	
Sample Type:	Convenience Additional Sample Information:				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	20.00	100.00	300.00	1000.00
Survey RVW:	0.19	1.25	2.75	3.50	6.50
Pre-Service Evaluation Time:			10.00		
Pre-Service Positioning Time:			5.00		
Pre-Service Scrub, Dress, Wait Time:			0.00		
Intra-Service Time:	0.00	10.00	40.00	45.00	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		
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); 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:	90868	Recommended Physician Work RVU: 0.76		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		2.00	7.00	-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:		10.00		
Immediate Post Service-Time:	4.00			
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	
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95978	XXX	3.50	RUC Time

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
76700	XXX	0.81	RUC Time	1,020,282

CPT Descriptor 1 Ultrasound, abdominal, real time with image documentation; complete

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
20551	000	0.75	RUC Time	201,322

CPT Descriptor 2 Injection(s); single tendon origin/insertion

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99231	XXX	0.76	RUC Time

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 21.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 90868	<u>Key Reference CPT Code:</u> 95978	<u>Source of Time</u> RUC Time
Median Pre-Service Time	2.00	5.00	
Median Intra-Service Time	10.00	60.00	
Median Immediate Post-service Time	4.00	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	16.00	70.00
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	4.20	4.00
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.93	3.73
--	------	------

Urgency of medical decision making	4.13	3.87
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.53	4.20
--------------------------	------	------

Physical effort required	4.00	3.53
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.87	4.00
---	------	------

Outcome depends on the skill and judgment of physician	4.47	4.13
--	------	------

Estimated risk of malpractice suit with poor outcome	3.47	3.73
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.53	3.60
----------------------------------	------	------

Intra-Service intensity/complexity	4.40	4.40
------------------------------------	------	------

Post-Service intensity/complexity	3.60	3.33
-----------------------------------	------	------

Additional Rationale and Comments

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

We are submitting the following recommendations for code 90868, *Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session*. We recommend an RVW of 0.76 with the following times: 5 minutes pre, 10 minutes intra, and 5 minutes post service for a total time of 20 minutes.

Background/History

Two codes, 0160T, *Therapeutic repetitive transcranial magnetic stimulation treatment planning*, and 0161T, *Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session*, describing therapeutic repetitive transcranial magnetic stimulation procedures were originally developed in 2007 as Category III codes within CPT. A coding change proposal was brought forward at the February 2010 CPT Editorial Panel meeting by the device manufacturer to change the status of these codes from Category III to Category I. The CPT Editorial Panel approved the request, creating two Category I codes that replicated the original Category III codes: 90867 described the initial planning session, which included the cortical mapping and the motor threshold determination; and a second code, 90868, described the stimulation treatment itself. The codes, as originally constructed, were forwarded to the RUC for review in April 2010.

The codes were pre-facilitated at that April meeting at the request of the society, during which a number of issues were identified, including the reallocation of the time components and the identification of a missing piece of work that was not accurately captured by either of the new codes. The society requested that the two codes be withdrawn from the RUC process until such time as a third code could be developed.

A coding change request proposal for the third code was developed and reviewed by CPT at its October 2010 meeting. The CPT Editorial Panel not only approved the request for the third code 9086XX, *Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management*, it also made revisions to the description of 90867 to more clearly define the work of the initial procedure. Specifically, a stimulation treatment session was included within the work described by a 90867 since the initial planning session is almost always followed by a stimulation treatment. To be clear, the current codes under survey do not have the same descriptions as those surveyed for the April 2010 RUC. The society made efforts to highlight the change in the descriptor of the code for the respondents, but it appears that many of those participating may not have taken this change into account when they completed the most recent survey. The results of that survey and our recommendations are presented within this SOR.

Analysis and Recommendations from the Expert Panel

The APA convened an expert panel to review the results of the survey. In a review of the data for 90868 our experts highlighted a number of items and made several recommendations:

1. In a review of the RUC standards for pre-service time packages, as with the previous code, the panel selected package 5, *Procedure without sedation/anesthesia care* with a pre-service evaluation of 7 minutes and positioning and scrub, dress and wait time of 0. The experts agreed that the median value for the pre-service evaluation time of 10 minutes (5 minutes for pre-service evaluation on the day prior to treatment and 5 minutes pre-service evaluation on the day of treatment) was excessive and should be reduced to 5 minutes, which is the value at the 25th percentile, and 2 minutes less than the standard package. **The expert panel recommended a total pre-service evaluation time of 5 minutes.**
2. The median survey response for the intra-service time was 40 minutes, and the 25th percentile response was 10 minutes. Our experts believed that the large disparity in numbers was due to several factors:
 - a. This is a new technology with variability in how these services are being performed. There are psychiatrists who are performing the full course of stimulation on each visit; others who are in the treatment room for a portion of the treatment and then are available should any complications develop;

and a smaller percentage of psychiatrists who supervise and manage the treatment but are not present in the treatment room, although they are available in the office should problems arise. The experts anticipate that as psychiatrists become more proficient, the number of psychiatrists performing the full course of stimulation each visit will diminish. However, the need for physician involvement will remain during the course of treatment to monitor the patient's mental state, and the physician needs to be immediately available to handle any complication of treatment such as seizure production. The psychiatrist is responsible for monitoring the patient's response to treatment, dealing with any significant side effects, and addressing any decline in psychiatric status.

b. The survey participants have limited experience in participating in the RUC survey process. When determining the intra-service time, it is possible that the physicians automatically put in the full treatment time rather than the time they spent performing the service. While treatments may last longer, the minimum amount of time that stimulation is provided is 37.5 minutes.

Our experts recommended the 25th percentile intra-service time, which is 10 minutes.

3. **Our expert panel recommends an RVW of 0.76**, which is below the 25th percentile RVW of 1.25 from the survey and equal to that of 99231, *Subsequent Hospital Care*, which has an RVW of 0.76 and times of 5 pre, 10 intra, and 5 post. Although not hospitalized, the patients seeking TMS treatment are those individuals suffering from major depressive disorder who have failed to achieve satisfactory improvement from one prior antidepressant medication at or above the minimal effective dose and duration in the current episode.

Conclusion

For the reasons discussed above, the expert panel **recommends the work RVW of 0.76 with a pre-service time of 5 minutes, an intra-service time of 10 minutes, and a post-service time of 5 minutes for a total time of 20 minutes.**

Medicare Frequency Estimates

We would like to request that this code be placed on the new technology list for review of the utilization. In a review of the available utilization data we found that 0161T was billed only 8 times for the 6 months of data available. A check of other unlisted services codes produced a total number of psychiatric claims under 30 so and estimate regarding the Medicare frequency data is difficult to develop.

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) 0161T

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 Psychiatry How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 150000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Review of available data re new patients in consultation with TMS experts

Specialty Psychiatry Frequency 150000 Percentage 100.00 %

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? 8 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Review of available data re new patients in consultation with TMS experts

Specialty Psychiatry Frequency 8 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? No

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

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. 90870, Electroconvulsive Therapy

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

CPT Code:90869 Tracking Number N3

Original Specialty Recommended RVU: **3.00**

Global Period: 000

Presented Recommended RVU: **3.20**RUC Recommended RVU: **3.20**

CPT Descriptor: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

(Do not report 9086XX in conjunction with 90867, 90868)

(If a significant, separately identifiable Evaluation and Management, medication management, psychotherapy or psychotherapy with evaluation and management service is performed, the appropriate E/M, psychotherapy, psychotherapy with E/M service or 90862 may be reported using modifier 25 in addition to 90867-9086XX. Evaluation and management activities directly related to delivery of TMS are not separately reported.)

(Psychotherapy with or without E/M or medication management services unrelated to the delivery of TMS may be reported separately.)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 50 year old female with a primary diagnosis consistent with DSM-IV defined Major Depressive Disorder, severe, with a recurrent course of illness, who presents for a routine daily TMS treatment. Since the last treatment, the patient's medication regimen has been revised to include clonazepam 1mg nightly, which is known to alter cortical excitability. This change makes it medically necessary for the physician to redetermine the motor threshold. The patient's motor threshold is redetermined after which the patient undergoes TMS treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 2%

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? 10%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Reviews the medical history including any potential increased risk for a seizure (e.g. history of head injury or past seizure, medications that could lower the seizure threshold) or potential risks associated with exposure to a magnetic field (e.g. implanted medical devices). In planning the TMS treatment consider patient characteristics to decide on the type of TMS to provide with respect to treatment site, frequency and intensity.

Description of Intra-Service Work: The physician performs a brief focused interview to determine patient's mental status and ability to proceed with the procedure. Confirms with the patient: identity, current medications, and any significant clinical changes. The physician responds to any patient questions.

Positioning the Patient and in particular positioning the Pt's head precisely by- centering the head in the head positioner, using the laser attachment to identify the midline, placing the positioning tape to stabilize head, and then locking the contralateral head support in place. The head positioner is adjusted along all 3 axes, and the parameters on each gauge are recorded.

Finding the Target Hand Muscle includes the following -- place the coil in the previously estimated location and use single pulse TMS to search for the target hand muscle. Increase intensity slowly until a muscle twitch is obtained in the hand and use a grid approach to find the target muscle. Once the target muscle contraction is found, then stimulate across the anterior-posterior plane to find the most anterior location and most posterior location that still produces a muscle twitch. Find the midpoint or area of maximal contraction and repeat this process along the medial-lateral plane. Find the cross point between these two planes and use this location to determine motor threshold

Determining Motor Threshold (MT) -- The MT value is defined as the lowest level of system output power that produces a visible movement in the targeted hand muscle. This is done using a computer program that calculates MT based on yes/no responses for stimulations at various intensities, or by using step-wise increases and decreases in intensity to identify at what intensity a contraction is seen in half of the stimulations.

Determining Treatment Site -- Advance 5-6 cm anteriorly from the motor cortex site of the target hand muscle along the superior oblique plane or determine the treatment site using the EEG-F3 method.

Treatment and Clinical Monitoring -- To initiate treatment the physician advances the treatment coil to the targeted treatment location and the prescribed treatment parameters are selected (frequency, intensity, number of stimuli, treatment train length and inter-stimulus interval). The coil must remain in good contact with the patient's head for the duration of treatment. During the treatment session the patient must be closely monitored at all times to ensure good coil-to-head contact to optimize penetration of the electromagnetic pulses to the cortex. The clinician monitors the patient's clinical status for comfort and tolerability and, if necessary, adjusts coil position and customizes the stimulation parameters to mitigate discomfort. Although the risk of a seizure is low (<1%) it is a significant medical complication, thus patients must be monitored for any signs or symptoms that may indicate the emergence of an ictal event, and the physician must be ready to respond if necessary. The physician leaves once it is determined that the treatment is proceeding appropriately.

Description of Post-Service Work: The pertinent information is documented in the patient's medical record. Communicate with other physicians, non-physician clinicians and/or family regarding any clinically relevant information.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011					
Presenter(s):	Jeremy Musher, MD, Patrick Marsh, MD, Shirlene Sampson, MD					
Specialty(s):	Psychiatry					
CPT Code:	90869					
Sample Size:	354	Resp N:	67	Response: 18.9 %		
Sample Type:	Convenience Additional Sample Information:					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	4.00	10.00	20.50	300.00
Survey RVW:		0.80	2.50	3.20	3.75	8.00
Pre-Service Evaluation Time:				20.00		
Pre-Service Positioning Time:				10.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		10.00	30.00	45.00	60.00	120.00
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			
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); 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:	90869	Recommended Physician Work RVU: 3.20		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		7.00	7.00	0.00
Pre-Service Positioning Time:		10.00	0.00	10.00
Pre-Service Scrub, Dress, Wait Time:		0.00	0.00	0.00
Intra-Service Time:		45.00		
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 0.0	99239x 0.0	
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? Yes

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95978	XXX	3.50	RUC Time

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99205	XXX	3.17	RUC Time	1,025,935

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95974	XXX	3.00	RUC Time

CPT Descriptor Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 22.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 90869	<u>Key Reference CPT Code:</u> 95978	<u>Source of Time</u> RUC Time
Median Pre-Service Time	17.00	5.00	
Median Intra-Service Time	45.00	60.00	
Median Immediate Post-service Time	10.00	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	72.00	70.00
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	4.07	3.87
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.13	3.80
Urgency of medical decision making	3.73	3.27

Technical Skill/Physical Effort (Mean)

Technical skill required	4.73	4.40
Physical effort required	3.73	3.20

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.93	4.20
Outcome depends on the skill and judgment of physician	4.60	4.20
Estimated risk of malpractice suit with poor outcome	3.33	3.67

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.60	3.60
Intra-Service intensity/complexity	4.47	4.20
Post-Service intensity/complexity	2.87	2.73

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.*

We are submitting the following recommendations for code 90869, *Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management*. We recommend an RVW of 3.0 and the following times of 5 minutes pre, 50 minutes intra, and 5 minutes post service for a total time of 60 minutes.

Background/History

Two codes, 0160T, *Therapeutic repetitive transcranial magnetic stimulation treatment planning*, and 0161T, *Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session*, describing therapeutic repetitive transcranial magnetic stimulation procedures were originally developed in 2007 as Category III codes within CPT. A coding change proposal was brought forward at the February 2010 CPT Editorial Panel meeting by the device manufacturer to change the status of these codes from Category III to Category I. The CPT Editorial Panel approved the request, creating two Category I codes that replicated the original Category III codes: 90867 described the initial planning session, which included the cortical mapping and the motor threshold determination; and a second code, 90868, described the stimulation treatment itself. The codes, as originally constructed, were forwarded to the RUC for review in April 2010.

The codes were pre-facilitated at that April meeting at the request of the society, during which a number of issues were identified, including the reallocation of the time components and the identification of a missing piece of work that was not accurately captured by either of the new codes. The society requested that the two codes be withdrawn from the RUC process until such time as a third code could be developed.

A coding change request proposal for the third code was developed and reviewed by CPT at its October 2010 meeting. The CPT Editorial Panel not only approved the request for the third code 90869, *Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management*, it also made revisions to the description of 90867 to more clearly define the work of the initial procedure. Specifically, a stimulation treatment session was included within the work described by a 90867 since the initial planning session is almost always followed by a stimulation treatment. To be clear, the current codes under survey do not have the same descriptions as those surveyed for the April 2010 RUC. The society made efforts to highlight the change in the descriptor of the code for the respondents, but it appears that many of those participating may not have taken this change into account when they completed the most recent survey. The results of that survey and our recommendations are presented within this SOR.

Analysis and Recommendations from the Expert Panel

The APA convened an expert panel to review the results of the survey. In a review of the data for 90869 our experts highlighted a number of items and made several recommendations:

1. Our panel selected pre-service evaluation package 5, *Procedure without sedation/anesthesia care* with a pre-service evaluation of 7 minutes and positioning and scrub, dress and wait time of 0. The experts agreed that the median value for the pre-service evaluation time of 20 minutes (10 minutes for pre-service evaluation on the day prior to treatment and 10 minutes pre-service evaluation on the day of treatment) was excessive, believing that the survey respondents failed to understand the question. They recommended that the minutes be reduced to 5 minutes, which is supported by the 25th percentile and is 2 minutes less than the standard package. **The expert panel recommended a total pre-service evaluation time of 5 minutes.**

2. Survey respondents included 10 minutes of positioning time, which is inherent in the cortical mapping as pre-service work rather than as intra-service work. According to the experts on our panel, it takes a minimum of 35 minutes to do the cortical mapping and motor threshold and dose redetermination. This would then be followed by a stimulation treatment. As with the 90867 code, there is variability in the amount of time spent by the physician performing the treatment session. However, our experts indicated that the typical time the physician remained in the room is 15 minutes, to ensure the patient is tolerating the treatment and it is progressing appropriately. Once leaving the room the physician remains available should problems arise and returns as necessary. Our panel recommended **moving the 10 minutes of positioning time to intra-service time, which results in 50 minutes total time for the intra-service period -- 35 minutes for cortical mapping and motor threshold determination, and 15 minutes for the provision of the first portion of the stimulation treatment.**

3. Our expert panel recommended an RVW of 3.0, which is slightly less than the median RVW of 3.2. The panel compared the 90869 to 95978, *Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour*, which has an RVW of 3.50 and pre, intra, and post times of 5, 60, and 5 for a total time of 70 minutes. The 95978 is similar in that it is stimulation of the brain, and both procedures are equally complex. In both the 90869 and the 95978 the physician is determining the best way to stimulate the brain. In both procedures, intensity is being manipulated. In the 90869, the physician is using the magnetic treatment coil and a series of pulses to find the most therapeutically beneficial site and dosage. In the 95978 the physician is trying to determine optimal electrode stimulation by varying frequency and intensity. The intra service time is slightly longer for the 95978, which has the higher RVW.

Conclusion

For the reasons discussed above, the expert panel **recommends the work RVW of 3.0 with a pre-service time of 5 minutes, an intra-service time of 50 minutes, and a post-service time of 5 minutes for a total time of 60 minutes.**

Medicare Frequency Data:

We would like to request that this be placed on the new technology list for review of the utilization. This code is a new code but would have likely been reported as a 0160T in the past.

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) 90899

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 Psychiatry How often? Sometimes

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 10000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Review of available data re new patients in consultation with TMS experts

Specialty Psychiatry Frequency 10000 Percentage 100.00 %

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? 1 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Review of available data re new patients in consultation with TMS experts

Specialty Psychiatry Frequency 1 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? No

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

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. 90870

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

CPT Long Descriptor: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, planning including cortical mapping, motor threshold determination, delivery and management

(Report only once per course of treatment)

(Do not report 90867 in conjunction with 95928, 95929, 90868, 9086XX)

(If a significant, separately identifiable Evaluation and Management, medication management, psychotherapy or psychotherapy with evaluation and management service is performed, the appropriate E/M, psychotherapy, psychotherapy with E/M service or 90862 may be reported using modifier 25 in addition to 90867-9086XX. Evaluation and management activities directly related to delivery of TMS are not separately reported.)

(Psychotherapy with or without E/M or medication management services unrelated to the delivery of TMS may be reported separately.)

Global Period: 000

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

Practice Expense Survey forms were sent to a randomly selected group of physicians that had participated in the RUC survey of physician work. Information received was compiled and presented for review by a panel comprised of representatives from the APA's Committee on RBRVS, Codes and Reimbursements and ad hoc APA members with experience in performing TMS. The panel refined the information to reflect current practice and current PEAC/PERC standards.

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: NA

Intra-Service Clinical Labor Activities: NA

Post-Service Clinical Labor Activities: NA

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

CPT Long Descriptor: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, planning including cortical mapping, motor threshold determination, delivery and management

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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:

On the day of the procedure the nurse/TMS technician (technician) prepares the room by turning on the machine, entering patient specific data into the computerized system, placing the Senstar disposable into the device and setting the arm of the machine to a neutral position. The technician retrieves the medical record and ensures that appropriate documentation is in the record. The technician greets the patient and gives the patient questionnaires/forms to complete (e.g., depression screening tool, medication list), once completed they are placed in the medical record for review by the physician. The technician confirms there are no metal objects that would interfere with treatment, reviews the procedure with the patient, responds to questions, and escorts the patient to the treatment room.

Intra-Service Clinical Labor Activities:

The technician provides the disposable items to the patient (ear plugs and liners) and ensures they are in place at the appropriate times. The physician is notified and once in the room, the physician reviews the informed consent and the procedure, securing any signatures as appropriate. The technician assists the physician in positioning the patient in the chair, including placing cushions to aid with patient comfort. The technician documents each aspect of the positioning from the placement of cushions to the recording of the location/height of the headset, etc. as the physician makes multiple adjustments to find the position that is best suited for the cortical mapping process. The technician remains in the room throughout the mapping and the process of determining the motor threshold, documenting key data points as the physician is doing the analysis, assisting by keeping the patient comfortable and physically still (placement of additional cushions/supports), and providing supportive care to the patient during the entire procedure. During the treatment stimulation portion of the procedure the technician documents the exact location of the treatment site and the exact positioning of the patient. The technician remains in the room throughout the full course of treatment and continuously observes to ensure there is sufficient contact of the coil with the patient's head, making the appropriate adjustments to the position of the coil to maintain sufficient contact. The technician monitors the patient for any discomfort and for signs of any complications such as emerging signs of a seizure, notifying the physician appropriately.

Post-Service Clinical Labor Activities:

The technician takes the disposable items from the patient and disposes of them. The technician responds to any questions from the patient, provides the patient with information on the next appointment, and enters data into the medical record. The technician notifies the physician that the treatment has been completed and provides patient specific information as to how the patient tolerated the procedure and any complications that arose, and at the appropriate time notifies the patient that the treatment is complete and that he can leave the office. The technician cleans the machine and removes any additional disposables.

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

CPT Long Descriptor: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session

(If a significant, separately identifiable Evaluation and Management, medication management, psychotherapy or psychotherapy with evaluation and management service is performed, the appropriate E/M, psychotherapy, psychotherapy with E/M service or 90862 may be reported using modifier 25 in addition to 90867-9086XX. Evaluation and management activities directly related to delivery of TMS are not separately reported.)

(Psychotherapy with or without E/M or medication management services unrelated to the delivery of TMS may be reported separately.)

Global Period: 000

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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: NA

Intra-Service Clinical Labor Activities: NA

Post-Service Clinical Labor Activities: NA

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

CPT Long Descriptor: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session

(If a significant, separately identifiable Evaluation and Management, medication management, psychotherapy or psychotherapy with evaluation and management service is performed, the appropriate E/M, psychotherapy, psychotherapy with E/M service or 90862 may be reported using modifier 25 in addition to 90867-9086XX. Evaluation and management activities directly related to delivery of TMS are not separately reported.)

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

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Intra-Service Clinical Labor Activities:

The technician provides the disposable items to the patient (ear plugs and liners) and ensures they are in place at the appropriate times. The physician is notified and once in the room, the physician

reviews the informed consent and responds to questions. The technician assists the physician in positioning the patient in the chair, including placing cushions to aid with patient comfort. The technician then documents any change in positioning. During the treatment stimulation portion of the procedure the technician documents the exact location of the treatment site and the exact positioning of the patient. The technician remains in the room throughout the full course of treatment and continuously observes to ensure there is sufficient contact of the coil with the patient's head, making the appropriate adjustments to the position of the coil to maintain sufficient contact. The technician monitors the patient for any discomfort and for signs of any complications such as emerging signs of a seizure, notifying the physician appropriately.

Post-Service Clinical Labor Activities:

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

CPT Long Descriptor: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

(Do not report 90869 in conjunction with 90867, 90868)

(If a significant, separately identifiable Evaluation and Management, medication management, psychotherapy or psychotherapy with evaluation and management service is performed, the appropriate E/M, psychotherapy, psychotherapy with E/M service or 90862 may be reported using modifier 25 in addition to 90867-90869. Evaluation and management activities directly related to delivery of TMS are not separately reported.)

(Psychotherapy with or without E/M or medication management services unrelated to the delivery of TMS may be reported separately.)

Global Period: 000

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

Practice Expense Survey forms were sent to a randomly selected group of physicians that had participated in the RUC survey of physician work. Information received was compiled and presented for review by a panel comprised of representatives from the APA's Committee on RBRVS, Codes and Reimbursements and ad hoc APA members with experience in performing TMS. The panel refined the information to reflect current practice and current PEAC/PERC standards.

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: NA

Intra-Service Clinical Labor Activities: NA

Post-Service Clinical Labor Activities: NA

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

CPT Long Descriptor: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

(Do not report 90869 in conjunction with 90867, 90868)

(If a significant, separately identifiable Evaluation and Management, medication management, psychotherapy or psychotherapy with evaluation and management service is performed, the appropriate E/M, psychotherapy, psychotherapy with E/M service or 90862 may be reported using modifier 25 in addition to 90867-90869. Evaluation and management activities directly related to delivery of TMS are not separately reported.)

(Psychotherapy with or without E/M or medication management services unrelated to the delivery of TMS may be reported separately.)

Global Period: 000

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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:

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Intra-Service Clinical Labor Activities:

The technician provides the disposable items to the patient (ear plugs and liners) and ensures they are in place at the appropriate times. The physician is notified and once in the room, the physician reviews the informed consent and explains the procedure, securing any signatures as appropriate. The technician assists the physician in positioning the patient in the chair, including placing cushions to aid with patient comfort. The technician documents each aspect of the positioning from the placement of cushions to the recording of the location/height of the headset, etc., as the physician makes multiple adjustments to find the position that is best suited for the cortical mapping process. The technician remains in the room throughout the process of re-evaluating the cortical mapping and motor threshold determination, documenting key data points as the physician is doing the analysis, assisting by keeping the patient comfortable and physically still (placement of additional cushions/supports), and providing supportive care to the patient during the entire procedure. During the treatment stimulation portion of the procedure the technician documents the exact location of the treatment site and the exact positioning of the patient. The technician remains in the room throughout the full course of treatment and continuously observes to ensure there is sufficient contact of the coil with the patient's head, making the appropriate adjustments to the position of the coil to maintain sufficient contact. The technician monitors the patient for any discomfort and for signs of any complications such as emerging signs of a seizure, notifying the physician appropriately.

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	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation			90867		90868		90869	
2	Meeting Date: February 2011 Tab 15 Transcranial Magnetic Stimulation			Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, planning including cortical mapping, motor threshold determination, delivery and management		Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session		Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	
		CMS	Staff						
3	LOCATION	Code	Type	Non Facility	Facility	Facility	Facility	Facility	Facility
4	GLOBAL PERIOD			000	000	000	000	000	000
5	TOTAL CLINICAL LABOR TIME			118.0	0.0	54.0	0.0	89.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0
7	TIME			118.0	0.0	54.0	0.0	89.0	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	Other Clinical Activity (please specify)								
12	End: When patient enters office/facility for surgery/procedure								
13	SERVICE PERIOD								
14	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure								
15	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		3		3	
16	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3					
17	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2	
18	Intra-service								
19	Prepare and position patient/ monitor patient								
20	Assist physician in performing procedure and monitoring the treatment	L037D	RN/LPN/MTA	99		42		77	
21	Post-Service								
22	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3		3	
23	Home care instructions/coordinate session visits /prescriptions	L037D	RN/LPN/MTA	5		3		3	
24	Complete forms/Develop hard copy/Archive data/Obtain approval for patient discharge	L037D	RN/LPN/MTA	3		1		1	
25	End: Patient leaves office								
26	POST-SERVICE Period								
27	Start: Patient leaves office/facility								
28	End: with last office visit before end of global period								
29	MEDICAL SUPPLIES								
			Unit						
30	Senstar Treatment Pack (Senstar treatment link, side arm, head and pad liners, ear plugs)	See Invoice	each	1		1		1	
31	NeuroStar® TMS Therapy System Extended Warranty	See Invoice	Yearly						
32	EQUIPMENT								
33	NeuroStar® TMS Therapy System	See invoice	each	104		47		82	

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation			90867		90868		90869	
2	Meeting Date: February 2011 Tab 15 Transcranial Magnetic Stimulation			Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, planning including cortical mapping, motor threshold determination, delivery and management		Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session		Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management	
		CMS	Staff						
3	LOCATION	Code	Type	Non Facility	Facility	Facility	Facility	Facility	Facility
4	GLOBAL PERIOD			000	000	000	000	000	000
5	TOTAL CLINICAL LABOR TIME			94.0	0.0	37.0	0.0	72.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	0.0
7	TIME			94.0	0.0	37.0	0.0	72.0	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	Other Clinical Activity (please specify)								
12	End: When patient enters office/facility for surgery/procedure								
13	SERVICE PERIOD								
14	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure								
15	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	3		3		3	
16	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	3					
17	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	2		2		2	
18	Intra-service								
19	Prepare and position patient/ monitor patient			15		15		15	
20	Assist physician in performing procedure and monitoring the treatment	L037D	RN/LPN/MTA	60		10		45	
21	Post-Service								
22	Clean room/equipment by physician staff	L037D	RN/LPN/MTA	3		3		3	
23	Home care instructions/coordinate session visits /prescriptions	L037D	RN/LPN/MTA	5		3		3	
24	Complete forms/Develop hard copy/Archive data/Obtain approval for patient discharge	L037D	RN/LPN/MTA	3		1		1	
25	End: Patient leaves office								
26	POST-SERVICE Period								
27	Start: Patient leaves office/facility								
28	End: with last office visit before end of global period								
29	MEDICAL SUPPLIES								
			Unit						
30	Senstar Treatment Pack (Senstar treatment link, side arm, head and pad liners, ear plugs)	See Invoice	each	1		1		1	
31	NeuroStar® TMS Therapy System Extended Warranty	See Invoice	Yearly						
32	EQUIPMENT								
33	NeuroStar® TMS Therapy System	See invoice	each	94		37		72	

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Fourth Five-Year Review - Harvard Valued – Utilization Over 30,000

April 2011

Contact Lens Fitting

In the 4th Five-Year Review of the RBRVS, CMS identified code 92070 *Fitting of contact lens for treatment of disease, including supply of lens* (work RVU = 0.70) through the Harvard-Valued – Utilization over 30,000 screen. Upon review of this service, the specialty societies agreed that there are two distinct uses for 92070 that have substantially different levels of work. In February 2011, the CPT Editorial Panel agreed and deleted code 92070 and created two new codes to distinguish reporting of fitting of contact lens for treatment of ocular surface disease and fitting of contact lens for management of keratoconus.

92071 *Fitting of contact lens for treatment of ocular surface disease*

The RUC reviewed the survey results from 66 ophthalmologists and optometrists who perform this procedure. Eighty-five percent of the survey respondents believed the vignette was typical and the code would typically be used on the same day as an Evaluation and Management visit. This service involves identifying and fitting of the correct therapeutic contact lens for the corneal damaged eye, to facilitate healing. Although the survey respondents indicated the typical physician intra-service work time requires 15 minutes, the specialty society and the RUC agreed that only five minutes was typical in comparison to similar services, with a total time of 15 minutes. The survey respondents chose 65205 *Removal of foreign body, external eye; conjunctival superficial* (000 day global, work RVU = 0.71) as its key reference service and the RUC agreed that this reference code, with identical physician time components, should be valued similarly to 92071. The RUC compared the work of this service to that of code 65778 *Placement of amniotic membrane on the ocular surface for wound healing; self-retaining* (010 day global, work RVU = 1.19) without its follow up visit. Although the survey indicated a median work RVU of 1.11, the specialty recommended, and the RUC agreed, that the original work value of 0.70 for CPT code 92070 was more appropriate. **The RUC recommends a work RVU of 0.70 for CPT code 92071.**

92072 *Fitting of contact lens for management of keratoconus*

The RUC accepted compelling evidence that this service is separate from the original 92070 service and has never been valued in the past. In addition, the original code 92070 and new code 92071 were valued unilaterally whereas 92072 appropriately has been surveyed as being typically performed bilaterally. In addition, keratoconus is not seen in the Medicare population and it is not covered.

The RUC reviewed the survey results from 61 ophthalmologists and optometrists who perform this procedure. The specialty recommended 10 minutes of pre-service time to account for the review of all referring data on the patient and an extensive educational discussion concerning lens trials with the patient. A reduced immediate post service time from the survey was also recommended by the specialty to be only 10 minutes rather than 20 minutes. The specialty indicated and the RUC agreed that the immediate post service time, 10 minutes, appropriately mirrors the post service time of 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program;*

comprehensive, new patient, 1 or more visits (work RVU = 1.82). The RUC determined that the surveyed code is more complex, requires more time, 65 total minutes compared to 40 minutes, and is more intense than the work associated with 92004. The intensity and complexity of 92072 requires the physician to manage a warped cornea to get the correct specialty designed contact lens fit in each eye. Each eye is pathologically unique and requires evaluating the correct fit with dye and light. Therefore, the RUC determined that the median work RVU of 1.97 appropriately accounts for the work required to perform this service. **The RUC recommends a work RVU of 1.97 for CPT code 92072**

Referral to CPT:

The RUC referred CPT code 92072 to the CPT Editorial Panel to add language to the code to clarify that the service is the initial service for treatment of keratoconus and that subsequent contact lens fittings would be coded with a general ophthalmological exam or Evaluation and Management service.

Practice Expense:

The RUC reviewed and refined the direct practice expense inputs for 92071 and 92072 to reflect the typical patient service.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery Eye and Ocular Adnexa Anterior Segment Cornea Other Procedures				
E 65775		Corneal wedge resection for correction of surgically induced astigmatism (For fitting of contact lens for treatment of disease, use 92070 <u>see, 92071, 92072</u>) (For unlisted procedures on cornea, use 66999)	090	6.91 (No Change)
Medicine Ophthalmology Special Ophthalmological Services				

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 92070		Fitting of contact lens for treatment of disease, including supply of lens (92070 has been deleted. To report, see 92071, 92072)	XXX	N/A
●92071	BB1	Fitting of contact lens for treatment of ocular surface disease (Do not report 92071 in conjunction with 92072) (Report supply of lens separately with 99070 or appropriate supply code)	XXX	0.70
●92072	BB2	Fitting of contact lens for management of keratoconus; <u>initial fitting</u> (For subsequent fittings, see E/M, 92012, 92014)) (Do not report 92072 in conjunction with 92071) (Report supply of lens separately with 99070 or appropriate supply code)	XXX	1.97
<p>Contact Lens Services</p> <p><i>The prescription of contact lens includes specification of optical and physical characteristics (such as power, size, curvature, flexibility, gas-permeability). It is NOT a part of the general ophthalmological services. The fitting of contact lens includes instruction and training of the wearer and incidental revision of the lens during the training period.</i></p> <p><i>Follow-up of successfully fitted extended wear lenses is reported as part of a general ophthalmological service (92012 et seq).</i></p> <p><i>The supply of contact lenses may be reported as part of the service of fitting. It may also be reported separately by using the appropriate supply codes.</i></p> <p>(For therapeutic or surgical use of contact lens, see 68340, 92070-92071, 92072)</p>				

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

CPT Code: 92071 Tracking Number BBI

Original Specialty Recommended RVU: **0.70**

Global Period: XXX

Presented Recommended RVU: **0.70**RUC Recommended RVU: **0.70**

CPT Descriptor: Fitting of contact lens for treatment of ocular surface disease

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 32 year-old male with eye pain, photophobia, and reduced vision after his eye was struck with a tree branch. He was found to have a corneal abrasion which requires a therapeutic contact lens to protect the corneal surface, reduce discomfort, and facilitate healing.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: The process involved in placing the therapeutic contact lens is reviewed with the patient along with the risks and benefits of the treatment .

Description of Intra-Service Work: Topical anesthesia is administered. A therapeutic soft contact lens of the appropriate size and base curve is selected and applied to the cornea. A drop of topical antibiotic is administered. Fifteen minutes later the fit and centration of the lens is evaluated at the slit lamp.

Description of Post-Service Work: A prescription for topical antibiotics and appropriate instructions are given and any necessary follow up is explained.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Stephen Kamenetzky, M.D. and Michael Chaglasian, O.D.				
Specialty(s):	Ophthalmology and Optometry				
CPT Code:	92071				
Sample Size:	450	Resp N:	66	Response: 14.6 %	
Sample Type:	Random	Additional Sample Information: A random sample from comprehensive members and those who specialize in cornea disorders			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	6.00	12.00	30.00
Survey RVW:		0.20	0.76	1.11	1.47
Pre-Service Evaluation Time:				5.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		10.00	15.00	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
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:	92071	Recommended Physician Work RVU: 0.70		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		5.00	7.00	-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:		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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
65205	000	0.71	RUC Time

CPT Descriptor Removal of foreign body, external eye; conjunctival superficial**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 1

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
65778	010	1.19	RUC Time

CPT Descriptor Placement of amniotic membrane on the ocular surface for wound healing; self-retaining**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 21.2 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 92071	<u>Key Reference CPT Code:</u> 65205	<u>Source of Time RUC Time</u>
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	5.00	5.00	
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	15.00	15.00	
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	3.08	2.77
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.69	2.54
--	------	------

Urgency of medical decision making	3.54	3.46
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Technical Skill/Physical Effort (Mean)

Technical skill required	3.15	3.62
--------------------------	------	------

Physical effort required	2.69	2.92
--------------------------	------	------

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	3.46	3.62
--	------	------

Estimated risk of malpractice suit with poor outcome	3.46	3.31
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.31	2.38
----------------------------------	------	------

Intra-Service intensity/complexity	3.31	3.54
------------------------------------	------	------

Post-Service intensity/complexity	2.69	2.69
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Additional Rationale and Comments

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

CPT 92070 *Fitting of contact lens for treatment of disease, including supply of lens* was selected for the fourth Five Year Review because it had a utilization of >30,000 and was Harvard valued. The AAO and the AOA requested that the code be referred to CPT in order to separate the two distinct

types of service defined by the code that have significantly different physician work and practice expense. Because the cost of a lens can vary widely, the societies also recommended that the supply of the lens be removed from the descriptor and a separate HCPCS code be used to report that cost. The RUC agreed and two new CPT codes were created. This code deals with the fitting of a bandage soft contact lens for the treatment of corneal disease.

The AAO and AOA each surveyed members and the results were combined. There were 66 responses with a response rate of 14.6%. Eighty-five percent thought that the vignette was typical. The median RVU was 1.14 and the 25th percentile 0.76. Median intra-service times were 5/15/8.5 minutes. The primary reference code chosen was CPT 65205 *removal of foreign body, external eye; conjunctival superficial* which has a WRVU of 0.71 and times of 5/5/5 minutes. The code would typically be used on the same day as an EM visit.

An expert panel familiar with the service and the RUC process reviewed the survey responses. It was felt that the times chosen by the respondents were too long and that times of 5/5/5 minutes would be more appropriate and these are the times that we are submitting for review. In addition to the reference code chosen, CPT 65778 *Placement of amniotic membrane on the ocular surface for wound healing; self-retaining* was felt to be a good comparison code. The code was reviewed by the RUC in Feb 2010 and a value of 1.19 was established with a 10day global period that included a 99212 visit to remove the carrier ring. Subtracting the 99212 work value of 0.48 results in a WRVU of 0.71. The times for 65778 are also 5/5/5 min and the services of placing a protective device on the eye to treat corneal surface disease are virtually identical. CPT 67820 *Correction of trichiasis; epilation, by forceps only (000)* has combined pre-and post-service times of 10 min, 5 min IST and a WRVU of 0.71. There are also a series of injection codes which have been RUC reviewed (CPT 64455, 20550, 20612 [000 global]) and have similar times with WRVU ranging from 0.71 to 0.75.

The AAO and AOA recommend the existing WRVU of 0.70 which is below the 25th percentile on the survey.

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 service is done in conjunction with an office visit

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. The MD or OD would bill one of the following visit codes at which time this scan would also be performed.

3.	CPT Code	Pre	Intra	Post-	Total Time	Work RVU	Global Period
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

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

CPT Code: 92072 Tracking Number BB2

Original Specialty Recommended RVU: **1.97**Presented Recommended RVU: **1.97**

Global Period: XXX

RUC Recommended RVU: **1.97**

CPT Descriptor: Fitting of contact lens for management of keratoconus

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 27 year-old female with keratoconus is unable to read or drive safely with glasses or conventional contact lenses. Her best corrected visual acuity is 20/60 OD, and 20/200 OS due to irregular astigmatism from keratoconus. A custom contact lens fit and design is medically necessary for visual rehabilitation.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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?

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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: The contact lens fitting process is reviewed with the patient along with the risks and benefits as well as long-term prognosis. Different lens fitting options are discussed along with the expectations for improved visual acuity.

Description of Intra-Service Work: Results of diagnostic tests done prior to contact lens fitting to assess the corneal ectasia are used in concert with slit lamp examination to assess corneal shape and determine initial contact lens parameters (e.g. diameter, base curve and secondary curves). Lens designs can include corneal, scleral, hybrid or piggyback systems. Keratometry, lid anatomy, tear film and refraction are also performed/rechecked.

An initial diagnostic lens is selected for each eye and placed on the eyes. The patient is examined after adequate time for the lens to settle in order to evaluate the lens fit. Fluorescein dye is instilled in the eye to evaluate the posterior tear pattern, lens position and corneal relationship. Based on the fit of the first diagnostic lens, the lens parameters are recalculated. This includes base curves, secondary curves and lens design. This process is repeated until the lens is well-centered and comfortable. A typical fitting requires three different diagnostic lenses per eye. An over-refraction is performed to determine final contact lens power.

Description of Post-Service Work: A suitable contact lens polymer is selected and final lens design parameters are calculated and prescribed. A technician discusses the appropriate discussions regarding lens handling and care, lens wear and potential complications are provided to the patient. Follow-up is arranged.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Stephen Kamenetzky, M.D. and Michael Chaglasian, O.D.				
Specialty(s):	Ophthalmology and Optometry				
CPT Code:	92072				
Sample Size:	450	Resp N:	61	Response: 13.5 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	10.00	30.00	84.00
Survey RVW:		0.90	1.80	1.97	2.29
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		10.00	30.00	45.00	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
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:	92072	Recommended Physician Work RVU: 1.97		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		10.00	7.00	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:		45.00		
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 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92004	XXX	1.82	RUC Time

CPT Descriptor Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
29445	000	1.78	RUC Time	13,152

CPT Descriptor 1 Application of rigid total contact leg cast

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99233	XXX	2.00	RUC Time	20,842,871

CPT Descriptor 2 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90937	000	2.11	RUC Time

CPT Descriptor Hemodialysis**RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):**Compare the pre-, intra-, and post-service time (by the median) and the 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: 78.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 92072	<u>Key Reference CPT Code:</u> 92004	<u>Source of Time</u> RUC Time
Median Pre-Service Time	10.00	5.00	
Median Intra-Service Time	45.00	25.00	
Median Immediate Post-service Time	10.00	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	65.00	40.00
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	4.04	3.77
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.44	3.69
--	------	------

Urgency of medical decision making	3.33	3.23
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.85	3.77
--------------------------	------	------

Physical effort required	3.85	3.19
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.75	3.27
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Outcome depends on the skill and judgment of physician	4.81	3.79
--	------	------

Estimated risk of malpractice suit with poor outcome	3.40	3.31
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.67	3.04
----------------------------------	------	------

Intra-Service intensity/complexity	4.70	3.64
------------------------------------	------	------

Post-Service intensity/complexity	4.06	3.08
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Additional Rationale and Comments

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

CPT 92070 *Fitting of contact lens for treatment of disease, including supply of lens* was selected for the fourth Five Year Review because it had a utilization of >30,000 and was Harvard valued. The AAO and the

AOA requested that the code be referred to CPT in order to separate the two distinct types of service defined by the code that have significantly different physician work and practice expense. Because the cost of a lens can vary widely, the societies also recommended that the supply of the lens be removed from the descriptor and a separate HCPCS code be used to report that cost. The RUC agreed and two new CPT codes were created by the Editorial Panel. This new code deals with the fitting of rigid contact lenses for the treatment of keratoconus, a condition that causes the normal dome-shaped cornea to progressively thin and form a cone-shaped bulge. This service is not typically performed in the Medicare population. The existing code would represent the service that will be coded by 9207X1 (being reviewed separately) which is a covered service. CPT code 9207X2 will represent a service not readily coded previously.

Compelling evidence to support our recommended work value: The work of fitting a contact lens for keratoconus is substantially more involved and utilizes many additional techniques than would be typical for 92070 or 9207X1. The keratoconus service was previously billed using the existing code which met the descriptor of the service, but not the work, techniques and lenses utilized which are substantially different and better represented with the new code 920X2.

The AAO and AOA each surveyed members and the results were combined. There were 61 responses with a response rate of 13.5%. Ninety-seven percent thought that the vignette was typical. The median RVU was 1.97 and the 25th percentile 1.80. Median intra-service times were 15/45/20 minutes. The primary reference code chosen was CPT 92004 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits* which has a WRVU of 1.82 and times of 5/25/10 minutes. The reference code chosen has an intra-service time which is 20 minutes less than 9207X2. The survey respondents felt that the intensities and complexities were similar in most areas. The one difference was that the successful outcome was dependent on the skill of the practitioner where the surveyed code was much higher than the reference code. The code would typically NOT be used on the same day as an E/M visit. The work value estimate was for fitting of both eyes which would be typical as keratoconus is a bilateral disease.

An expert panel familiar with the service and the RUC process reviewed the survey responses. Fitting of lenses in patients with keratoconus is a time-consuming process involving the assessment of the fit of a series of trial contact lenses of known material, diameter and base curve. About 3 lenses are tried per eye to achieve the desired size and base curve that produces a stable fit. Each evaluation takes about 6 minutes/eye to assess the fit at slit lamp and calculate the changes needed improve vision and comfort. Usually the two eyes behave entirely independently due to the asymmetric nature of the pathology. After the proper lens is selected, an over-refraction of that lens is done to determine the proper power. This process takes about 45 minutes (18 min/eye x 2+refraction of each eye) which is the survey IST. The panel felt that the survey pre- and post-times were too long and therefore we are recommending times of 10/45/10.

There are several 000 global RUC reviewed codes with times similar to the code being surveyed. CPT 90937 *Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription* has a WRVU of 2.11 with time of 10/40/10. CPT 11921 *Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm* has the same IST, longer pre- and post-times and a WRVU of 1.93. CPT 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient* has similar pre- and post- times and only 30 minutes of IST and has a WRVU of 2.00. The surveyed code is less intense and complex than 99233, but has an IST that is 50 % longer.

The specialties recommend the median WRVU of 1.97.

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

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. 92070

	A	B	C	D	E	F	G
1	AMA Specialty Society RVS Update Committee Recommendation			92071		92072	
2	Meeting Date: April 2011			Fitting of Contact Lens for Rx of ocular surface disease		Fitting of Contact Lens for management of Keratoconus	
		CMS	Staff				
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			xxx	xxx	xxx	xxx
5	TOTAL CLINICAL LABOR TIME			5.0	0.0	48.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			5.0	0.0	42.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	6.0	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	Greet patient, provide gowning, ensure appropriate medical records are available						
21	Obtain vital signs						
22	Provide pre-service education/obtain consent		L038A			2	
23	Prepare room, equipment, supplies		L038A			2	
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		L038A	5		15	
29	Post-Service						
30	Monitor pt. following service/check tubes, monitors, drains						
31	Clean room/equipment by physician staff		L038A			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	Teach insert/remove, care		L038A			20	
39	End: Patient leaves office						
40	POST-SERVICE Period						
41	Start: Patient leaves office/facility						
42	Conduct phone calls/call in prescriptions		L038A			6	
43	<i>Office visits:</i>						
44	<i>List Number and Level of Office Visits</i>						
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	<i>Total Office Visit Time</i>			0	0	0	0
52	Other Activity (please specify)						
53	End: with last office visit before end of global period						
54	MEDICAL SUPPLIES		Unit				
55	Ophthalmology visit package	SA050				1	
56							
57							
58							
59	Equipment						
60	screening lane	EL006		11		42	
61	keratoconus contact lens fitting set					42	
62							

	A	B	C	D	E	F	G
1	AMA Specialty Society RVS Update Committee Recommendation			92071		92072	
2	Meeting Date: April 2011	CMS	Staff	Fitting of Contact Lens for Rx of ocular surface disease		Fitting of Contact Lens for management of Keratoconus	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD			xxx	xxx	xxx	xxx
5	TOTAL CLINICAL LABOR TIME			5.0	0.0	48.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			5.0	0.0	42.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	0.0	6.0	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	Greet patient, provide gowning, ensure appropriate medical records are available						
21	Obtain vital signs						
22	Provide pre-service education/obtain consent		L038A			2	
23	Prepare room, equipment, supplies		L038A			2	
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		L038A	5		15	
29	Post-Service						
30	Monitor pt. following service/check tubes, monitors, drains						
31	Clean room/equipment by physician staff		L038A			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	Teach insert/remove, care		L038A			20	
39	End: Patient leaves office						
40	POST-SERVICE Period						
41	Start: Patient leaves office/facility						
42	Conduct phone calls/call in prescriptions		L038A			6	
43	<i>Office visits:</i>						
44	<i>List Number and Level of Office Visits</i>						
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	<i>Total Office Visit Time</i>			0	0	0	0
52	Other Activity (please specify)						
53	End: with last office visit before end of global period						
54	MEDICAL SUPPLIES		Unit				
55	Ophthalmology visit package	SA050				1	
56							
57							
58							
59	Equipment						
60	screening lane	EL006		15		42	
61	keratoconus contact lens fitting set					42	
62							

Typical Patient (9207X1)

A 32 year-old male with eye pain, photophobia, and reduced vision after his eye was struck with a tree branch. He was found to have a corneal abrasion which requires a therapeutic contact lens to protect the corneal surface, reduce discomfort, and facilitate healing.

Typical Patient (9207X2)

A 27 year-old female with keratoconus is unable to read or drive safely with glasses or conventional contact lenses. Her best corrected visual acuity is 20/60 OD, and 20/200 OS due to irregular astigmatism from keratoconus. A custom contact lens is designed and fit.

AMA/Specialty Society RVS Update Committee Summary of Recommendations
 Fourth Five-Year Review - Harvard Valued – Utilization Over 30,000

April 2011

Tonography

In the 4th Five-Year Review of the RBRVS, CMS identified codes 92120 and 92130 through the Harvard-Valued – Utilization over 30,000 screen. In April 2010, the specialty societies indicated that an editorial revision of 92120 was necessary to clarify the reporting between tonography and 0198T *Ocular blood flow measurement*. In February 2011, the CPT Editorial Panel agreed with the specialty’s recommendations. In April 2011, the RUC reviewed 92120 and 92130 and concluded these are low volume services based upon the fact that a survey could not be performed and that virtually all reporting is incorrect coding, as these services should be reported with the Category III code 0198T *Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report*. With the support of the ophthalmology and optometry the RUC requested that CPT delete these services during the 2012 CPT cycle. **The RUC recommended CPT codes 92120 and 92130 to the CPT Editorial Panel for deletion.**

Subsequent to the RUC’s April 2011 recommendation, the CPT Editorial Panel approved the deletion of codes 92120 and 92130 for CPT 2012.

CPT Code	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲ 92120	CC1	Tonography for measurement of aqueous humor outflow facility, with interpretation and report, recording indentation tonometer method or perilimbal suction method (92120, 92130 have been deleted. Ocular blood flow measurements are reported with 0198T. Single-episode tonometry is a component of general ophthalmological service or E/M service.) (For measurement of ocular blood flow, use Category III code 0198T)	XXX	NA
92130	CC2	Tonography with water provocation	XXX	NA

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment – Codes Reported Together 75% or More Screen

April 2011

Pulmonary Function Testing

In February 2010, CPT codes 94240, 94260, 94350, 94360, 94370 and 94725 were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These codes are commonly billed together with 94720, 94360, 94240 and 94350. In February 2011, the specialty submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The Panel created four bundled services for RUC review in April 2011. The specialty informed the RUC that these tests are not automated.

94726 Plethysmography for determination of lung volumes and, when performed, airway resistance

The RUC reviewed the survey results from 40 pulmonary physicians for CPT code 94726. The RUC recommends pre-service time of 5 minutes, intra-service time of 5 minutes and post-service time of 5 minutes. The RUC reviewed the Medicare claims data for the services that this code is bundling and noted that an Evaluation and Management service is not typically billed on the same date of service. The RUC reviewed the survey work values and agreed with the specialty that the respondents accurately valued the service at the 25th percentile, a work RVU of 0.31. To further justify this value, the RUC compared the physician work of 94726 to the key reference code 94375 *Respiratory flow volume loop* (work RVU= 0.31) and agreed that while the reference code has greater intra-service time compared the surveyed code, 7 minutes compared to 5 minutes, the survey respondents rated 94726 as a more intense and complex procedure. Therefore, the work values should be identical. Also, the RUC compared 94726 to the reference code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU= 0.30) and agreed that these services have similar intensity and complexity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.31 for CPT code 94726.**

94727 Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes

The RUC reviewed the survey results from 36 pulmonary physicians for CPT code 94727. The RUC recommends pre-service time of 5 minutes, intra-service time of 5 minutes and post-service time of 5 minutes. The RUC reviewed the Medicare claims data for the services that this code is bundling and noted that an Evaluation and Management service is not typically billed on the same date of service. The RUC reviewed the survey's estimated work values and agreed with the specialty that the respondents accurately valued the service at the 25th percentile, a work RVU of 0.31. To further justify this value, the RUC compared 94727 to the key reference code 94375 *Respiratory flow volume loop* (work RVU= 0.31) and agreed that while the reference code has greater intra-service time compared to the surveyed code, 7 minutes and 5 minutes, the survey respondents rated 94727

as a more intense and complex procedure. Therefore, the work values should be identical. Also, the RUC compared 94727 to CPT code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU= 0.30) and agreed that these services have similar intensity and complexity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.31 for CPT code 94727.**

94728 Airway resistance by impulse oscillometry

The RUC reviewed the survey results from 31 pulmonary physicians for CPT code 94728. The RUC recommends pre-service time of 5 minutes, intra-service time of 5 minutes and post-service time of 5 minutes. The RUC reviewed the Medicare claims data for the services that this code is bundling and noted that an Evaluation and Management service is not typically billed on the same date of service. In addition, the specialty explained that while 94728 and 94727 can be billed together, this is not typical as the typical scenario for 94728 involves a pediatric patient. The RUC reviewed the survey work values and agreed with the specialty that the respondents accurately valued the service at the 25th percentile, a work RVU of 0.31. To further justify this value, the RUC compared 94728 to the reference code 94375 *Respiratory flow volume loop* (work RVU= 0.31) and agreed that while the reference code has greater intra-service time compared to the surveyed code, 7 minutes and 5 minutes, 94728 is a more intense procedure compared to the reference code. Therefore, the work values should be identical. Also, the RUC compared 94728 to the reference code 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only* (work RVU= 0.30) and agreed that these services have similar intensity and complexity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.31 for CPT code 94728.**

94729 Diffusing capacity (eg, carbon monoxide, membrane)

The RUC reviewed the survey results from 42 pulmonary physicians for CPT code 94729. The RUC recommends intra-service time of 5 minutes for this ZZZ global code. The RUC reviewed the survey's estimated work values and agreed that the survey respondents overestimated the work value of this procedure. To determine an appropriate work value for this procedure, the RUC reviewed other ZZZ global codes with similar physician work. The RUC reviewed 93352 *Use of echocardiographic contrast agent during stress echocardiography* (work RVU= 0.19) and agreed that this service has comparable physician work and intensity with identical intra-service time of 5 minutes. Therefore, the work value of 94729 should be directly crosswalked to 93352. To further justify a work RVU of 0.19, the RUC compared the surveyed code to the reference code 96415 *Chemotherapy administration, intravenous infusion technique; each additional hour* (work RVU= 0.19) and agreed that the two services have similar physician work and intensity with identical intra-service time of 5 minutes. **The RUC recommends a work RVU of 0.19 for CPT code 94729.**

Work Neutrality

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

Practice Expense

The RUC had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. Clinical labor was specifically refined to reflect the typical patient service. It was also recommended and agreed there were no direct inputs in the facility setting for this service.

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
D 93720		Plethysmography, total body; with interpretation and report	XXX	N/A
D 93721		Plethysmography, total body; tracing only, without interpretation and report	XXX	N/A
D 93722		Plethysmography, total body; interpretation and report only (For regional plethysmography, see 93875-93934) (93720-93722 have been deleted. To report, use 94726.)	XXX	N/A
E 94010		Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation (Do not report 94010 in conjunction with 94728, 94150, 94200, 94375 in conjunction with 94010)	XXX	0.17 (No Change)
94060		Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration (Do not report 94060 in conjunction with 94728, 94150, 94200, 94375 in conjunction with 94060)	XXX	0.31 (No Change)
E 94150		Vital capacity, total (separate procedure)	XXX	0.07 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(Do not report 94150 in conjunction with 94728, 94010, 94060 in conjunction with 94150 To report thoracic gas volumes, see 94726, 94727.)		
E 94200		Maximum breathing capacity, maximal voluntary ventilation (Do not report 94200 in conjunction with 94010, 94060 in conjunction with 94200)	XXX	0.11 (No Change)
D 94240		Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method	XXX	N/A
D 94260		Thoracic gas volume (For plethysmography, see 93720-93722) (94240, 94260 have been deleted. To report thoracic gas volumes, see 94726, 94727.)	XXX	N/A
D 94350		Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time (94350 has been deleted. To report, use 94726,94727.)	XXX	N/A
D 94360		Determination of resistance to airflow, oscillatory or plethysmographic methods (94360 has been deleted. To report, see 94726, 94728.)	XXX	N/A
D 94370		Determination of airway closing volume, single breath tests (94370 has been deleted. To report, use 94726, 94727.)	XXX	N/A
E 94375		Respiratory Flow Volume Loop	XXX	0.31 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(Do not report 94375 in conjunction with 94728, 94010, 94060)		
D 94720		Carbon monoxide diffusing capacity (eg, single breath, steady state)	XXX	N/A
D 94725		Membrane diffusion capacity (94720, 94725 have been deleted. To report, see 94729.)	XXX	N/A
●94726	FF1	Plethysmography for determination of lung volumes and when performed, airway resistance (Do not report 94726 in conjunction with 94727, 94728)	XXX	0.31
●94727	FF2	Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes (Do not report 94727 in conjunction with 94726)	XXX	0.31
●94728	FF3	Airway resistance by impulse oscillometry (Do not report 94728 in conjunction with 94726, 94010, 94060, 94070, 94375)	XXX	0.31
● +94729	FF4	Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure) (Report 94729 in conjunction with 94726-94728, 94010, 94060, 94070, 94375)	ZZZ	0.19

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

CPT Code: 94726 Tracking Number FF1

Original Specialty Recommended RVU: **0.31**Presented Recommended RVU: **0.31**

Global Period: XXX

RUC Recommended RVU: **0.31**

CPT Descriptor: Plethysmography for determination of lung volumes and when performed, airway resistance (Do not report 94726 in conjunction with 94727, 94728)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male complains of respiratory symptoms. Pulmonary function tests using body plethysmography are performed.

Percentage of Survey Respondents who found Vignette to be Typical: 80.00%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review results of previous Pulmonary Function Testing
- Review order request and diagnosis to ensure that ordered tests were performed
- Review accuracy of race, gender, age, height, smoking status

Description of Intra-Service Work:

- Verify that predicted values are correct for the patient tested
- Review pressure volumes curves from plethysmography
- Review pressure/flow results from airway resistance
- Check results for errors in the 3-8 maneuvers as noted by the RN/RT.
- Interpret the test results.
- Record interpretation and findings in the patient record.

Description of Post-Service Work:

- Review transcribed report, check for errors and sign the corrected report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011					
Presenter(s):	Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, ATS					
Specialty(s):	American College of Chest Physicians and the American Thoracic Society					
CPT Code:	94726					
Sample Size:	153	Resp N:	40	Response: 26.1 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	37.50	100.00	200.00	1000.00
Survey RVW:		0.22	0.31	0.40	0.61	1.00
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	3.00	5.00	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:	94726	Recommended Physician Work RVU: 0.31		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		5.00		
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
94375	XXX	0.31	RUC Time

CPT Descriptor Respiratory flow volume loop**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94010	XXX	0.00	RUC Time	1,256,953
<u>CPT Descriptor 1</u> Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94621	XXX	1.42	RUC Time	9,849

CPT Descriptor 2 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 13 % of respondents: 32.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 94726	<u>Key Reference CPT Code:</u> 94375	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	5.00	7.00	
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	15.00	17.00	

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	2.85	2.69
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.62	2.46
--	------	------

Urgency of medical decision making	2.38	2.31
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.85
--------------------------	------	------

Physical effort required	1.23	1.23
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.15	2.08
---	------	------

Outcome depends on the skill and judgment of physician	3.08	2.92
--	------	------

Estimated risk of malpractice suit with poor outcome	2.15	2.08
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.31	2.08
----------------------------------	------	------

Intra-Service intensity/complexity	2.77	2.62
------------------------------------	------	------

Post-Service intensity/complexity	2.62	2.54
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Additional Rationale and Comments

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

The Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

Specialty Pulmonary Disease	Frequency 240867	Percentage 76.70 %
Specialty Internal Medicine	Frequency 67016	Percentage 21.34 %
Specialty Critical Care	Frequency 6154	Percentage 1.95 %

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

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. 93720

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

CPT Code:94727 Tracking Number FF2

Original Specialty Recommended RVU: **0.31**Presented Recommended RVU: **0.31**

Global Period: XXX

RUC Recommended RVU: **0.31**

CPT Descriptor: Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes (Do not report 94727 in conjunction with 94726)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male complains of respiratory symptoms. Pulmonary function tests assessed by gas dilution are performed.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Reviewing results of previous Pulmonary Function Testing.
- Review order request and diagnosis to ensure that ordered tests were performed
- Review accuracy of race, gender, age, height, smoking status

Description of Intra-Service Work:

- Verify that predicted values are correct for the patient tested
- Review nitrogen wash-out or helium wash-in curves
- Interpret the test results.
- Record interpretation and findings in the patient record.

Description of Post-Service Work:

- Review transcribed report, check for errors and sign the corrected report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, ATS				
Specialty(s):	American College of Chest Physicians and the American Thoracic Society				
CPT Code:	94727				
Sample Size:	153	Resp N:	36	Response: 23.5 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	5.00	32.50	200.00
Survey RVW:		0.17	0.31	0.41	0.61
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	4.00	5.00	10.00
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
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:	94727	Recommended Physician Work RVU: 0.31		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		5.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
94375	XXX	0.31	RUC Time

CPT Descriptor Respiratory flow volume loop**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94010	XXX	0.17	RUC Time	1,256,953
<u>CPT Descriptor 1</u> Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94621	XXX	1.42	RUC Time	9,849

CPT Descriptor 2 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 13 % of respondents: 36.1 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 94727	<u>Key Reference CPT Code:</u> 94375	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	5.00	
Median Intra-Service Time	5.00	7.00	
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	15.00	17.00	

Other time if appropriate		
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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	2.92	2.85
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.85	2.69
--	------	------

Urgency of medical decision making	2.23	2.38
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.15	2.92
--------------------------	------	------

Physical effort required	1.25	1.25
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.23	2.15
---	------	------

Outcome depends on the skill and judgment of physician	3.23	3.15
--	------	------

Estimated risk of malpractice suit with poor outcome	2.23	2.23
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.38	2.23
----------------------------------	------	------

Intra-Service intensity/complexity	2.85	2.69
------------------------------------	------	------

Post-Service intensity/complexity	2.69	2.54
-----------------------------------	------	------

Additional Rationale and Comments

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

The Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

Specialty Pulmonary Disease	Frequency 217220	Percentage 69.17 %
Specialty Internal Medicine	Frequency 36523	Percentage 11.63 %
Specialty Critical Care	Frequency 9422	Percentage 3.00 %

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

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. 94240

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

CPT Code: 94728 Tracking Number FF3

Original Specialty Recommended RVU: **0.31**Presented Recommended RVU: **0.31**

Global Period: XXX

RUC Recommended RVU: **0.31**

CPT Descriptor: Airway resistance by impulse oscillometry (Do not report 94728 in conjunction with 94726, 94010, 94060, 94070, 94375)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A four-year-old boy presents with respiratory symptoms. Diagnostic pulmonary function tests by impulse oscillometry are performed.

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 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Reviewing results of previous Pulmonary Function Testing
- Review order request and diagnosis to ensure that ordered tests were performed
- Review accuracy of race, gender, age, height, smoking status

Description of Intra-Service Work:

- Verify that predicted values are correct for the patient tested
- Review resistance and reactance distribution over different phases of tidal breathing
- Checking results for errors in the 3-8 maneuvers before and after the administration of the bronchodilator as noted by the RN/RT.
- Interpret the test results.
- Record interpretation and findings in the patient record.

Description of Post-Service Work:

- Review transcribed report, check for errors and sign the corrected report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, ATS				
Specialty(s):	American College of Chest Physicians and the American Thoracic Society				
CPT Code:	94728				
Sample Size:	153	Resp N:	31	Response: 20.2 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	0.00	5.00	28.75
Survey RVW:		0.15	0.31	0.50	0.73
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	4.50	10.00	10.00
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
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:	94728	Recommended Physician Work RVU: 0.31		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		5.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
94010	XXX	0.17	RUC Time

CPT Descriptor Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94010	XXX	0.17	RUC Time	1,256,953
<u>CPT Descriptor 1</u> Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94621	XXX	1.42	RUC Time	9,849

CPT Descriptor 2 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 9 % of respondents: 29.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 94728	<u>Key Reference CPT Code:</u> 94010	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	0.00	
Median Intra-Service Time	5.00	5.00	
Median Immediate Post-service Time	5.00	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	15.00	7.00
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	3.00	2.89
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	2.89
--	------	------

Urgency of medical decision making	3.00	2.67
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.89
--------------------------	------	------

Physical effort required	1.67	1.56
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	1.89
---	------	------

Outcome depends on the skill and judgment of physician	3.11	2.89
--	------	------

Estimated risk of malpractice suit with poor outcome	1.89	2.00
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.11	1.78
----------------------------------	------	------

Intra-Service intensity/complexity	2.44	2.11
------------------------------------	------	------

Post-Service intensity/complexity	2.22	2.11
-----------------------------------	------	------

Additional Rationale and Comments

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

The Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

Specialty Internal Medicine Frequency 14713 Percentage 9.09 %

Specialty Critical Care Frequency 7179 Percentage 4.44 %

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

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. 94375

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

CPT Code:94729 Tracking Number FF4

Original Specialty Recommended RVU: **0.30**Presented Recommended RVU: **0.30**

Global Period: ZZZ

RUC Recommended RVU: **0.19**

CPT Descriptor: Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure) (Report 94729 in conjunction with 94726-94728, 94010, 94060, 94070, 94375)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old man complains of shortness of breath. In addition to other pulmonary function tests, diffusing capacity is performed to assess for emphysema or interstitial lung disease.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:**Description of Intra-Service Work:**

- Verify that predicted values are correct for the patient tested
- Check results for errors in the 2-3 maneuvers as noted by the RN/RT.
- Check inspired vital capacity values for comparison to vital capacity
- Check breath hold times
- Interpret the test results.
- Record interpretation and findings in the patient record.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):		Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, ATS			
Specialty(s):		American College of Chest Physicians and the American Thoracic Society			
CPT Code:		94729			
Sample Size:	153	Resp N:	42	Response: 27.4 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	31.50	100.00	275.00
Survey RVW:		0.03	0.30	0.39	2.00
Pre-Service Evaluation Time:				0.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		1.00	3.00	5.00	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 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
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:	94729	Recommended Physician Work RVU: 0.19		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		5.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
94375	XXX	0.31	RUC Time

CPT Descriptor Respiratory flow volume loop**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
N/A		0.00		
<u>CPT Descriptor 1</u>				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		
<u>CPT Descriptor 2</u>				

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		0.00	
<u>CPT Descriptor</u>			

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 20 % of respondents: 47.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 94729	<u>Key Reference CPT Code:</u> 94375	<u>Source of Time RUC Time</u>
Median Pre-Service Time	0.00	5.00	
Median Intra-Service Time	5.00	7.00	
Median Immediate Post-service Time	0.00	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	5.00	17.00	
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	2.55	2.35
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.35	2.40
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Urgency of medical decision making	2.25	2.35
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.80	2.60
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Physical effort required	1.55	1.55
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.90	1.90
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Outcome depends on the skill and judgment of physician	2.80	2.80
--	------	------

Estimated risk of malpractice suit with poor outcome	1.90	1.90
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.00	2.00
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Intra-Service intensity/complexity	2.65	2.45
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Post-Service intensity/complexity	2.42	2.42
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Additional Rationale and Comments

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

The Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

Specialty Pulmonary Disease	Frequency 701296	Percentage 78.10 %
Specialty Internal Medicine	Frequency 88717	Percentage 9.88 %
Specialty Critical Care	Frequency 34302	Percentage 3.82 %

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

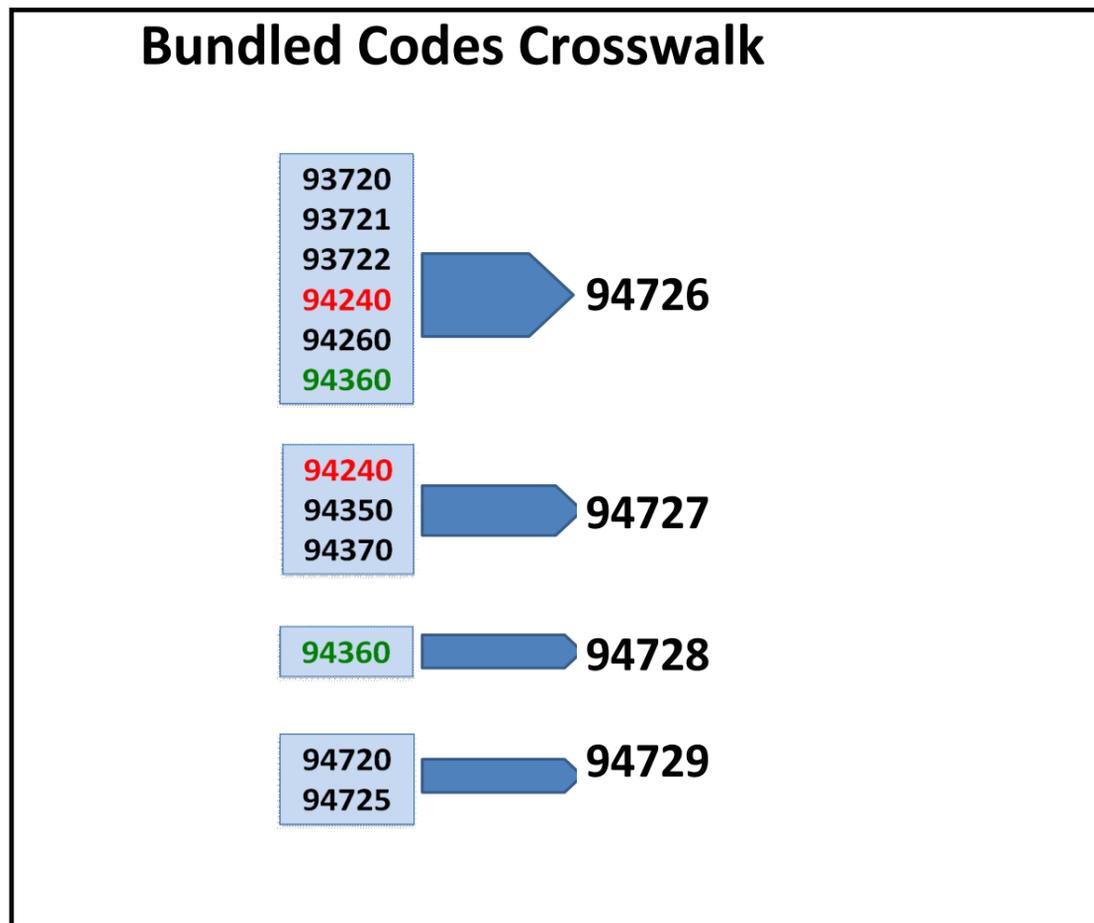
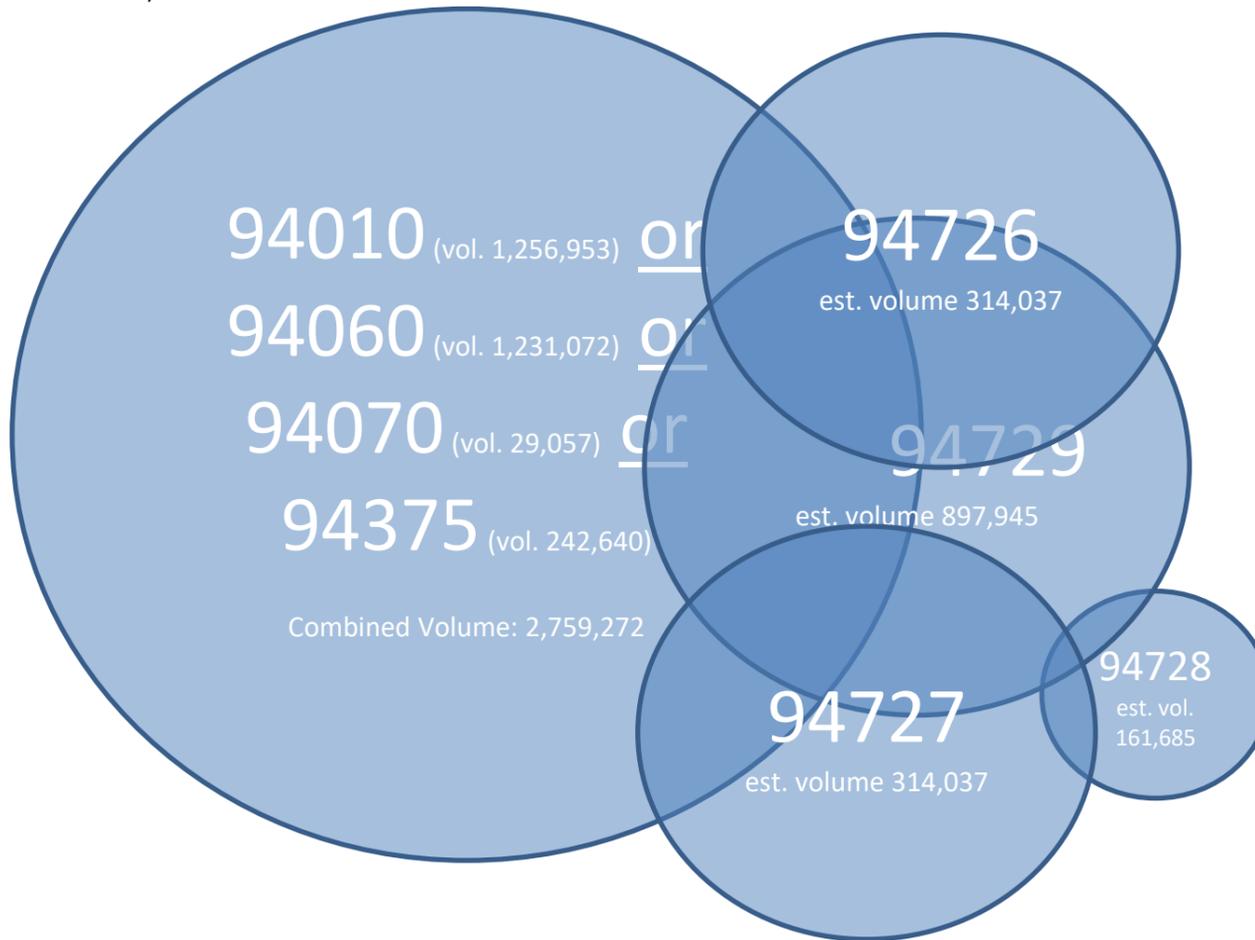
Professional Liability Insurance Information (PLI)

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

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. 94720

Revised Family of Pulmonary Function Testing Codes

Instructions: Only codes in the below diagram that are overlapping can be reported with each other. If circles are not directly touching, then those codes cannot be reported with each other (ie 94726 and 94728 cannot be reported together because they are not overlapping; 94726 can be billed with either 94010 or 94060 or 94070 or 94375 or 94729).



AMA Specialty Society RVS Update Committee Recommendation

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

Global Period: XXX for 94726-94728 and ZZZ for 94729

CPT Long Descriptors:

94726: Plethysmography for determination of lung volumes and when performed, airway resistance (Do not report 94726 in conjunction with 94727, 94728)

94727: Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes (Do not report 94727 in conjunction with 94726)

94728: Airway resistance by impulse oscillometry (Do not report 94728 in conjunction with 94726, 94010, 94060, 94070, 94375)

+94729: Diffusing capacity (eg, carbon monoxide, membrane) (List separately in addition to code for primary procedure) (Report 94729 in conjunction with 94726-94728, 94010, 94060, 94070, 94375)

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

The ACCP and ATS convened a consensus panel to develop recommendations for these codes. The composition of this panel included private practice and academic pulmonologists in varying types of practices and locations.

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

94726-94729 are 4 codes that are bundling 10 deleted codes. Below is a table showing the 10 codes that are being deleted and which of the 4 bundled codes they correspond with. The grouping was done by methodology.

Old Code	New Code	Descriptor
93720	94726	Plethysmography, total body; with interpretation and report
93721	94726- TC	Plethysmography, total body; tracing only, without interpretation and report
93722	94726- 26	Plethysmography, total body; interpretation and report only
94240	94726 94727	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method
94260	94726 94727	Thoracic gas volume
94350	94727	Determination of maldistribution of inspired gas: multiple breath nitrogen washout curve including alveolar nitrogen or helium equilibration time
94370	94727	Determination of airway closing volume, single breath tests
94360	94726 94728	Determination of resistance to airflow, oscillatory or plethysmographic methods
94720	94729	Carbon monoxide diffusing capacity (eg, single breath, steady state)

AMA Specialty Society RVS Update Committee Recommendation

94725	94729	Membrane diffusion capacity
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Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

- None

Intra-Service Clinical Labor Activities:

- Greets patient, determines time of last meal, alcohol ingestion or tobacco use, ask about eardrum perforation to assess whether plugging of ears will be necessary, determine potential infectious risk
- Prepares room, determines barometric pressure, readies equipment including calibration and supplies
- Provides explanation of the test to the patient/family, instruction and/or counseling
- Obtain height (sometimes via arm span), weight, blood pressure, SpO2 and pulse rate.
- Perform procedure via Plethysmography/ Gas dilution/ Oscillometry
- Coach patient through the procedure, adjusting nose clips as needed
- Cleans room and equipment
- Prints and documents all tests and evaluates the best effort

Post-Service Clinical Labor Activities:

- Review interpretation and coordinate with other providers

94726: Explanation of PE

Greet patient, ensure appropriate medical records are available: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for greeting the patient. However, since the procedure is typically performed on the same day as an E/M, this time is incorporated into the E/M visit. Therefore no time is allotted.

Obtain Vital Signs: Our consensus panel determined that vital signs are taken, including 6 vital signs, which would be assigned 5 minutes. However, since 3 vital signs (3 minutes) are contained within the E/M visit, only the difference of 2 minutes is included in the total clinical labor time for these studies.

Provide Pre-Service Education/ Obtain Consent: Our experts determined that this task takes approximately 4 minutes for Plethysmography.

Preparing Room, Equipment and Supplies: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing the room, equipment and supplies.

Prepare and Position Patient: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing and positioning the patient.

AMA Specialty Society RVS Update Committee Recommendation

Performing the Procedure: Our experts determined that we could crosswalk the time of this task to the currently accepted time for 93720, Plethysmography, 25 minutes.

Monitoring the Patient Following the Service: Our consensus panel determined that 3 minutes is appropriate.

Clean Room/ Equipment by Physician Staff: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for cleaning the room and equipment by the physician staff.

Complete diagnostic forms, lab and X-ray requisitions: 3 minutes are allotted to select the appropriate data to include in the report and print the report.

Home Care Instructions/ Coordinate Office Visits/ Prescriptions: Our consensus panel determined that 3 minutes is appropriate. This may include walking the patient/family back to another location for ongoing care.

Other Clinical Activities; Review Interpretation and Coordinate with Other Providers: Our consensus panel has determined that this task should be 3 minutes.

94726: Explanation of Medical Supplies

The medical supplies used for 94726 are crosswalked from 93720, Plethysmography, with the following exceptions:

Glutaraldehyde and glutaraldehyde test strips are no longer deemed typical. A thermometer cover is no longer typical. 4 sheets of paper are used to print out the results. One ounce of disinfectant is used for cleaning.

Also, the oxygen usage would be 50 liters. This is calculated by the total clinical labor time minus the time in the body plethysmograph (50 minutes minus 25 minutes=25 min) multiplied by 2 liter per minute flow.

94726: Explanation of Equipment

The only equipment used for this Plethysmography is a Vmax 229 (PFT equip, computer system) and is used for 50 minutes.

94727: Explanation of PE

Greet patient, ensure appropriate medical records are available: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for greeting the patient. However, since the procedure is typically performed on the same day as an E/M, this time is incorporated into the E/M visit. Therefore no time is allotted.

AMA Specialty Society RVS Update Committee Recommendation

Obtain Vital Signs: Our consensus panel determined that vital signs are taken, including 6 vital signs, which would be assigned 5 minutes. However, since 3 vital signs (3 minutes) are contained within the E/M visit, only the difference of 2 minutes is included in the total clinical labor time for these studies.

Provide Pre-Service Education/ Obtain Consent: Our experts determined that this task takes approximately 4 minutes for Gas Dilution. This is supported by the amount currently used for 94240, Residual Lung Capacity.

Preparing Room, Equipment and Supplies: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing the room, equipment and supplies.

Prepare and Position Patient: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing and positioning the patient.

Performing the Procedure: Our experts determined that we could crosswalk the time of this task to the currently accepted time for 94240, Residual Lung Capacity, 10 minutes.

Monitoring the Patient Following the Service: Our consensus panel determined that 3 minutes is appropriate.

Clean Room/ Equipment by Physician Staff: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for cleaning the room and equipment by the physician staff.

Complete diagnostic forms, lab and X-ray requisitions: 3 minutes are allotted to select the appropriate data to include in the report and print the report.

Home Care Instructions/ Coordinate Office Visits/ Prescriptions: Our consensus panel determined that 3 minutes is appropriate. This may include walking the patient/family back to another location for ongoing care.

Other Clinical Activities; Review Interpretation and Coordinate with Other Providers: Our consensus panel has determined that this task should be 3 minutes.

94727: Explanation of Medical Supplies

For Gas Dilution, a pulmonary function filter, a mouthpiece, a noseclip and nonsterile gloves are 50 liters of oxygen are typically used, which is the same amount we are using for 94726. This is calculated by the total clinical labor time minus the time in the body plethysmograph (35 minutes minus 10 minutes=25 min) multiplied by 2 liter per minute flow used. 4 sheets of paper are used to print out the results. One ounce of disinfectant is used for cleaning.

Glutaraldehyde and glutaraldehyde test strips are no longer deemed typical.

AMA Specialty Society RVS Update Committee Recommendation

94727: Explanation of Equipment

Our experts have determined that the use of a Vmax 229 (PFT equip, computer system) and a pulse oximeter w-printer are typical and both are used for 35 minutes.

94728: Explanation of PE

Greet patient, ensure appropriate medical records are available: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for greeting the patient. However, since the procedure is typically performed on the same day as an E/M, this time is incorporated into the E/M visit. Therefore no time is allotted.

Obtain Vital Signs: Our consensus panel determined that vital signs are taken, including 6 vital signs, which would be assigned 5 minutes. However, since 3 vital signs (3 minutes) are contained within the E/M visit, only the difference of 2 minutes is included in the total clinical labor time for these studies.

Provide Pre-Service Education/ Obtain Consent: Our experts determined that this task takes approximately 5 minutes for airway resistance by impulse oscillometry. This is chiefly to explain to parents the procedures involved.

Preparing Room, Equipment and Supplies: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing the room, equipment and supplies.

Prepare and Position Patient: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing and positioning the patient.

Performing the Procedure: Our experts determined that we could crosswalk the time of this task to the currently accepted time for 94375, Respiratory Flow Volume Loop, 14 minutes. This involves performing pre- and post-bronchodilator tests. The wait time after administration of bronchodilator is not included, as it assumes the technician will be working on other activities during the wait period.

Monitoring the Patient Following the Service: No monitoring of the patient after testing is needed.

Clean Room/ Equipment by Physician Staff: Our consensus panel's estimate for this task is 3 minutes, which is the PE standard for cleaning the room and equipment by the physician staff.

Complete diagnostic forms, lab and X-ray requisitions: 3 minutes are allotted to select the appropriate data to include in the report and print the report.

Other Clinical Activities; Review Interpretation and Coordinate with Other Providers: Our consensus panel has determined that this task should be 3 minutes.

94728: Explanation of Medical Supplies

AMA Specialty Society RVS Update Committee Recommendation

For Airway resistance by impulse oscillometry, a nebulizer mouthpiece with tubing, a pulmonary function filter, a mouthpiece, a noseclip and nonsterile gloves are used. 4 sheets of paper are used to print out the results. One ounce of disinfectant is used for cleaning.

Glutaraldehyde and glutaraldehyde test strips are no longer deemed typical.

94728: Explanation of Equipment

For Airway resistance by impulse oscillometry, our experts have determined that an oscillometry machine (invoice included with submission) is typical and is used for 34 minutes.

94729: Explanation of PE

Greet patient, ensure appropriate medical records are available: As this is a ZZZ add-on code, no time is allotted for this.

Obtain Vital Signs: As this is a ZZZ add-on code, no time is allotted for this.

Provide Pre-Service Education/ Obtain Consent: Our experts agreed that this task takes approximately 1 minute for Diffusing Capacity. This is chiefly to explain the use of carbon monoxide for inhalation.

Preparing Room, Equipment and Supplies: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing the room, equipment and supplies.

Prepare and Position Patient: Our consensus panel determined that the PE standard of 2 minutes is appropriate for preparing and positioning the patient.

Performing the Procedure: Our experts determined that we could crosswalk the time of this task to the currently accepted time for 94720, Monoxide Diffusing Capacity, 20 minutes.

Monitoring the Patient Following the Service: Our consensus panel determined that 3 minutes is appropriate.

Clean Room/ Equipment by Physician Staff: Due to the fact that 94729 will be a ZZZ code (add-on code), we have decided not to include any value for cleaning the room, as this would already be included in the other code being billed with 94729.

Hemoglobin adjustment: One minute is allowed for the technician to look up the most recent hemoglobin level and adjust the calculations to reflect this value.

Complete diagnostic forms, lab and X-ray requisitions: 1 minute is allotted to select the appropriate data to include in the report and print the report.

Home Care Instructions/ Coordinate Office Visits/ Prescriptions: As this is a ZZZ add-on code, no time is allotted for this.

AMA Specialty Society RVS Update Committee Recommendation

Other Clinical Activities; Review Interpretation and Coordinate with Other Providers: Due to the fact that 94729 will be a ZZZ code (add-on code), we have decided not to include any value for other clinical activities, as this would already be included in the other code being billed with 94729.

94729: Explanation of Medical Supplies

For Diffusing Capacity, a pulmonary function filter, a mouthpiece, a noseclip and nonsterile gloves are used. 4 sheets of paper are used to print out the results. One ounce of disinfectant is used for cleaning.

For inhalant our experts have determined that about 5 liters of the DLCO gas mix are used for three different measurements, which is 15 liters of the four gas mix (N₂, O₂, He, CO). This will measure out to around 25 grams.

Glutaraldehyde and glutaraldehyde test strips are no longer deemed typical.

94729: Explanation of Equipment

For Diffusing Capacity, our experts have determined that only a Vmax 62j (body plethysmograph autobox) is typical and used for 30 minutes.

	A	B	C	D	E	F	G	H	I	J	K
1	AMA Specialty Society RVS Update Committee Recommendation			94726		94727		94728		94729	
2	Meeting Date: April 2011	CMS	Staff	Plethysmography for determination of lung		Gas dilution or washout for determination of lung		Airway resistance by impulse oscillometry		Diffusing Capacity (eg, carbon monoxide,	
3	LOCATION	Code	Type	Non Facility (existing)	Non Facility (Proposed 2012)	Non Facility (existing)	Non Facility (Proposed 2012)	Non Facility (existing)	Non Facility (Proposed 2012)	Non Facility (existing)	Non Facility (Proposed 2012)
4	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX	XXX	XXX	ZZZ
5	TOTAL CLINICAL LABOR TIME	L047C	RN/RT	60.0	50.0	31.0	35.0	45.0	34.0	39.0	30.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L047C	RN/RT	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L047C	RN/RT	50.0	47.0	31.0	32.0	45.0	31.0	39.0	30.0
8	TOTAL POST-SERV CLINICAL LABOR TIME	L047C	RN/RT	5.0	3.0	0.0	3.0	0.0	3.0	0.0	0.0
9	PRE-SERVICE										
10	Start: Following visit when decision for surgery or procedure made										
11	Other Clinical Activity (please specify) Review Hx and medication use (O2, nebulizer, metered dose inhaler usage, especially the timing of the last usage; and also cardiac and hypertensive meds)	L047C	RN/RT	5	0		0		0		0
12	End: When patient enters office/facility for surgery/procedure										
13	SERVICE PERIOD										
14	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure										
15	Review Charts	L047C	RN/RT		0	1	0	1	0	1	0
16	Greet patient, ensure appropriate medical records are available	L047C	RN/RT	2	0	1	0	3	0	1	0
17	Obtain vital signs	L047C	RN/RT	3	2	3	2	3	2	2	0
18	Provide pre-service education/obtain consent	L047C	RN/RT		4	5	4	8	5	3	1
19	Prepare room, equipment, supplies	L047C	RN/RT	2	2	2	2	5	2	4	2
20	Prepare and position patient/ monitor patient/ set up IV	L047C	RN/RT	5	2		2	3	2	2	2
21	Intra-service										
22	Performing procedure	L047C	RN/RT	25	25	10	10	14	14	20	20
23	Post-Service										
24	Monitor pt. following service/check tubes, monitors, drains	L047C	RN/RT		3	3	3	4	0		3
25	Clean room/equipment by physician staff	L047C	RN/RT	3	3	3	3	3	3	3	0
26	Education/Instruction/Counseling	L047C	RN/RT	10							
27	Complete diagnostic forms, lab & X-ray requisitions	L047C	RN/RT		3		3	1	3		1
28	Hemoglobin adjustment	L047C	RN/RT								1
29	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	L047C	RN/RT		3	3	3			3	0
30	End: Patient leaves office										
31	POST-SERVICE Period										
32	Start: Patient leaves office/facility										
33	Conduct phone calls/call in prescriptions			5	0						
34	Other Activity (please specify) Review interpretation and coordinate with other providers	L047C	RN/RT		3		3		3		
35	End: with last office visit before end of global period										
36	MEDICAL SUPPLIES			Unit							
37	filter, pulmonary function filter	SD075	item	1	1		1	1	1		1
38	mouthpiece, respiratory	SD099	item	1	1		1		1	1	1
39	nebulizer mouthpiece with tubing	SD101	item					1	1		
40	noseclips	SD102	item	1	1	1	1	1	1	1	1
41	gloves, non-sterile	SB022	pair	1	1	1	1		1		1
42	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	2	0		0		0		0
43	glutaraldehyde test strips (Cidex, Metrex)	SM019	item	1	0						
44	cover, thermometer probe	SB004	item	1	0	1	0	1	0	1	0
45	inhalant	SH042	gm	0.25	0		0.25				25
46	gas, oxygen	SD084	liter	66	50		50			150	
47	paper, laser printing (each sheet)	SK057	item		4		4	4	4	4	4
48	disinfectant, surface (Envirocide, Sanizide)	SM013	oz		1	1	1	1	1	1	1
49	swab-pad, alcohol	SJ053	item			4					
50	Equipment										
51	Vmax 62j (body plethysmograph autobox)	EQ044	minutes			1				1	30
52	pulse oximeter w-printer	EQ211	minutes			1	35				
53	Vmax 229 (PFT equip, computer system)	EQ039	minutes	1	50		35	1	0		
54	computer, desktop, w-monitor	ED021		1				1			
55	Oscillometry (see included invoice)		minutes						34		

AMA/Specialty Society RVS Update Committee Summary of Recommendations

February 2011

Car Seat/Bed Evaluation

At the October 2010 Meeting, the CPT Editorial Panel created two codes to report car seat testing which is re-administered to the patient in the private physician's office. These services are performed on an infant who fails the car seat test in the hospital and is currently using the less safe car bed until s/he passes a car seat test administered by the child's physician.

94780 Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes

The RUC reviewed the survey data for 94780 from 35 pediatricians. The specialty society explained that the survey respondents over-estimated the service times and work RVUs associated with this surveyed code given the fact that this service is typically performed with an evaluation and management service on the same date of service. Therefore, the specialty society is recommending that the surveyed code's work RVU and service times be crosswalked directly from 99212 *Office or other outpatient visit for the evaluation and management of an established patient*, (work RVU=0.48; pre-service time=2 minutes, intra-service time=10 minutes and post-service time=4 minutes). The specialty society agreed that these times and work RVUs accurately reflect the time and intensity required to perform this service. The RUC agreed with the specialty society's recommended time and work RVU for 94780. **The RUC recommends a work RVU of 0.48 for CPT code 94780.**

94781 Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes

The RUC reviewed the survey data for 94781 from 31 pediatricians. The specialty society explained that the survey respondents over-estimated the service times and work RVUs associated with this surveyed code given the fact that this service is always performed with the base code 94780 on the same date of service. Therefore, the specialty society is recommending that the surveyed code's work RVU and intra-service time be crosswalked directly from 99211 *Office or other outpatient visit for the evaluation and management of an established patient*, (work RVU=0.17; intra-service time=5 minutes). The specialty society agreed that this service requires no additional pre-service or post-service time beyond the time of the base code, 94780. The specialty society also presented another reference code with the same intra-service time and work RVU as the surveyed code to further support the value and time proposed by the specialty, 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU=0.17; intra-service time=5 minutes) The specialty society agreed that these times and work RVUs accurately reflect the time and intensity required to perform this service. The RUC agreed with the specialty society's recommended time and work RVU for 94781. **The RUC recommends a work RVU of 0.17 for CPT code 94781.**

Practice Expense Inputs:

The RUC reviewed the practice expense inputs as submitted by the specialty society and removed the pulse oximetry as it is duplicative with the ECG equipment associated with this service. With this modification, the RUC accepted the practice expense inputs.

CPT Referral:

As this car seat testing is administered in the facility setting when the child is being discharged from the hospital and re-administered in the child's physician office, the RUC was concerned about differential work when the service was performed in either setting. The specialty society explained that facility services would occur when the infant was being discharged from the intensive care setting and the physician services would be performed by the neonatologist caring for the infant. The RUC agreed that an appropriate way to address the concern was to bundle car seat testing services when the child is being discharged from the hospital into the neonatal/infant per diem codes. The RUC also requested a parenthetical excluding simultaneous reporting of pulse oximetry and electrocardiographic monitoring, which is inherent in the car seat evaluation. At the February 2011 Meeting, the CPT Editorial Panel added language to these codes to address the concerns raised by the RUC.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●94780	D1	Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes (Do not report 94780 for less than 60 minutes) <u>(Do not report 94780 in conjunction with 93040-93042, 94760, 94761, 99468-99472, 99477-99480)</u>	XXX	0.48
±●94781	D2	each additional full 30 minutes (List separately in addition to code for primary procedure) (Use 94781 in conjunction with 94780)	ZZZ	0.17

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

CPT Code: 94780 Tracking Number D1 Original Specialty Recommended RVU: **0.98**
Presented Recommended RVU: **0.48**
Global Period: XXX RUC Recommended RVU: **0.48**

CPT Descriptor: Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes
(Do not report 94780 for less than 60 minutes)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An infant born at 35 weeks' gestation requires and fails a car seat/bed test before discharge from the hospital and is sent home in a car bed. The parent brings the child to the physician's office for retesting to determine whether the infant is medically stable to transition to a car seat.

Percentage of Survey Respondents who found Vignette to be Typical: 63%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 14%

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? 11%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The patient's medical records are reviewed to determine if car seat/bed testing is required. If risk criteria are identified, the parents are informed of the rationale for the test. A car seat/bed test is then ordered.

Description of Intra-Service Work: The physician reviews the results, interprets them, and documents his/her recommendation in the medical record.

Description of Post-Service Work: The physician communicates the result and determines the plan of care for transporting the infant.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011					
Presenter(s):	Steve Krug, MD, Gil Martin, MD, & Stephen Pearlman, MD					
Specialty(s):	American Academy of Pediatrics (AAP)					
CPT Code:	94780					
Sample Size:	152	Resp N:	35	Response: 23.0 %		
Sample Type:	Random Additional Sample Information: Surveyees selected from among the AAP's 60,000 members					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	6.00	40.00	100.00	400.00
Survey RVW:		0.10	0.28	0.98	1.20	2.75
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		0.00	5.00	10.00	19.00	60.00
Immediate Post Service-Time:	15.00					
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			
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); 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:	94780	Recommended Physician Work RVU: 0.98		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		10.00		
Immediate Post Service-Time:	4.00			
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	
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
99232	XXX	1.39	RUC Time

CPT Descriptor Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99462	XXX	0.62	RUC Time	4

CPT Descriptor 1 Subsequent hospital care, per day, for evaluation and management of normal newborn

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99460	XXX	1.17	RUC Time	1

CPT Descriptor 2 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
94620	XXX	0.64	RUC Time

CPT Descriptor Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 28.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 94780	<u>Key Reference CPT Code:</u> 99232	<u>Source of Time</u> RUC Time
Median Pre-Service Time	2.00	10.00	
Median Intra-Service Time	10.00	20.00	
Median Immediate Post-service Time	4.00	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	16.00	40.00
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	3.00	3.10
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.80	2.90
--	------	------

Urgency of medical decision making	3.00	2.70
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.00	2.90
--------------------------	------	------

Physical effort required	2.00	2.50
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.50	3.00
---	------	------

Outcome depends on the skill and judgment of physician	3.40	3.40
--	------	------

Estimated risk of malpractice suit with poor outcome	4.00	3.50
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.70	2.70
----------------------------------	------	------

Intra-Service intensity/complexity	2.90	3.10
------------------------------------	------	------

Post-Service intensity/complexity	3.30	3.20
-----------------------------------	------	------

Additional Rationale and Comments

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

An AAP expert panel reviewed the survey results and given the quality of the data, recommended the survey medians.

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) Car seat/bed testing is performed as a separate service for newborns being cared for under an evaluation and management (E/M) code.

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. The requested service is typically reported with another evaluation and management (E/M) service (ie, 99381, 99391; 99201-99205, 99212-99215) on the same date of service when performed as an outpatient. The parent will bring the infant to the primary care pediatrician for a well visit or preventive medicine visit (99381, 99391) or for a new sick visit (99201-99205) or follow-up visit (99212-99215). During this office visit, car seat/bed testing will be provided. When performed as an inpatient, a subsequent hospital care code (99231-99233) or a discharge day management code (99238-99239) will be reported on the same calendar date. This study can also be performed as a separate procedure in the office and represent the only E/M service provided to the child on that date of service.

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 Pediatrics 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? 290000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. N/A

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? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. N/A

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

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. 99478

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

CPT Code:94781 Tracking Number D2 Original Specialty Recommended RVU: **0.45**
Presented Recommended RVU: **0.17**
Global Period: ZZZ RUC Recommended RVU: **0.17**

CPT Descriptor: Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes (List separately in addition to code for primary procedure)
(Use 94781 in conjunction with 94780)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An infant born at 35 weeks' gestation requires and fails a car seat/bed test before discharge from the hospital and is sent home in a car bed. The parent brings the child to the physician's office for retesting to determine whether the infant is medically stable to transition to a car seat.

Percentage of Survey Respondents who found Vignette to be Typical: 68%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 6%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: N/A

Description of Intra-Service Work: The physician reviews the results, interprets them, and documents his/her recommendation in the medical record.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011					
Presenter(s):	Steve Krug, MD, Gil Martin, MD, & Stephen Pearlman, MD					
Specialty(s):	American Academy of Pediatrics (AAP)					
CPT Code:	94781					
Sample Size:	152	Resp N:	31	Response: 20.3 %		
Sample Type:	Random Additional Sample Information: Surveyees selected from among the AAP's 60,000 members					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	2.00	15.00	30.00	100.00
Survey RVW:		0.05	0.17	0.45	0.51	1.50
Pre-Service Evaluation Time:				5.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		0.00	5.00	10.00	15.00	30.00
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			
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); 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:	94781	Recommended Physician Work RVU: 0.45		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		5.00		
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	
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96367	ZZZ	0.19	RUC Time

CPT Descriptor 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)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94060	XXX	0.31	RUC Time	1,210,026
<u>CPT Descriptor 1</u> Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration				
<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93016	XXX	0.45	RUC Time	1,180,090

CPT Descriptor 2 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; physician supervision only, without interpretation and report

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
94010	XXX	0.17	RUC Time

CPT Descriptor Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 32.2 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 94781	<u>Key Reference CPT Code:</u> 96367	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	5.00	5.00	
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	5.00	6.00
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	1.80	1.60
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	1.60	1.70
--	------	------

Urgency of medical decision making	1.60	1.70
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	1.60	2.00
--------------------------	------	------

Physical effort required	1.10	1.50
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.00	1.90
---	------	------

Outcome depends on the skill and judgment of physician	1.70	1.80
--	------	------

Estimated risk of malpractice suit with poor outcome	2.30	2.20
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.40	1.30
----------------------------------	------	------

Intra-Service intensity/complexity	1.60	1.70
------------------------------------	------	------

Post-Service intensity/complexity	1.70	1.50
-----------------------------------	------	------

Additional Rationale and Comments

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

An AAP expert panel reviewed the survey results and given the quality of the data, recommended the survey medians.

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

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. 99478

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

**CPT Long Descriptor: Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes
(Do not report 94780 for less than 60 minutes)**

Global Period: XXX

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

An expert panel consisting of members of the American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature and Section on Perinatal Pediatrics developed the direct practice expense input recommendations based on the typical patient.

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

N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The nurse reviews the physician order for car seat/bed testing, collects & sets up cardiorespiratory monitoring equipment, and creates a monitoring documentation log.

Intra-Service Clinical Labor Activities:

The patient is placed in a car seat/bed in a reclining position appropriate for infant transport. The nurse undresses the infant and connects the cardiorespiratory leads and the pulse oximeter. The patient is then continuously observed by the nurse for a minimal of 60 minutes or the length of the car ride home, whichever is longer, with observations recorded at 5 minute intervals. Desaturations to levels <90% for 3-5 minutes in duration, apnea = or >20 seconds, or bradycardia = or <80 beats/minute are noted as well as any repositioning or stimulation needed during that time. Oxygen saturation, respiratory rate and heart rate are recorded continuously throughout the study period. The nurse records all data and informs the physician of the result.

Post-Service Clinical Labor Activities:

Once the patient is cleared by the physician, the nurse educates the family on proper car seat use.

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

CPT Long Descriptor: **Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes (List separately in addition to code for primary procedure)
(Use 94781 in conjunction with 94780)**

Global Period: **ZZZ**

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 consisting of members of the American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature and Section on Perinatal Pediatrics developed the direct practice expense input recommendations based on the typical patient.

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

N/A

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

N/A

Intra-Service Clinical Labor Activities:

The patient is placed in a car seat/bed in a reclining position appropriate for infant transport. The nurse undresses the infant and connects the cardiorespiratory leads and the pulse oximeter. The patient is then continuously observed by the nurse for an additional 30 minutes, with observations recorded at 5 minute intervals. Desaturations to levels <90% for 3-5 minutes in duration, apnea = or >20 seconds, or bradycardia = or <80 beats/minute are noted as well as any repositioning or stimulation needed during that time. Oxygen saturation, respiratory rate and heart rate are recorded continuously throughout the study period. The nurse records all data and informs the physician of the result.

Post-Service Clinical Labor Activities:

N/A

	A	B	C	D	E	F	G
1	AMA/Specialty Society RVS Update Society Recommendation			94780		94781	
2	Meeting Date: February 2011			Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; 60 minutes (Do not report 94780 for less than 60 minutes)		Car seat/bed testing for airway integrity, neonate, with continual nursing observation and continuous recording of pulse oximetry, heart rate and respiratory rate, with interpretation and report; each additional full 30 minutes (List separately in addition to code for primary procedure) (Use 94781 in conjunction with 94780)	
		CMS	Staff				
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD						
5	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	70.0	0.0	30.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	5.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	65.0	0.0	30.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			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): The nurse reviews the physician order for car seat/bed testing, collects & sets up cardiorespiratory monitoring equipment, and creates a monitoring documentation log.	L037D	RN/LPN/MTA	5			
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	Perform procedure	L037D	RN/LPN/MTA	60		30	
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	Other Clinical Activity (please specify): Once the patient is cleared by the physician, the nurse educates the family on proper car seat use.	L037D	RN/LPN/MTA	5			
38	End: Patient leaves office						
39	POST-SERVICE Period						
40	Start: Patient leaves office/facility						
41	Conduct phone calls/call in prescriptions						
42	Office visits: None						
43	Other Activity (please specify)						
44	End: with last office visit before end of global period						
45	MEDICAL SUPPLIES		Unit				
46	Oximetry sensor wrap	SD104		1			
47	Electrode, ECG (single)	SD053		1			
48							
49	Equipment						
50	ECG, 3-channel (with SpO2, NIBP, temp, resp)	EQ011		65			

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment – Codes Reported Together 75% or More Screen

April 2011

EMG in Conjunction with Nerve Testing

In February 2010, CPT codes 95860, 95861, 95863 and 95864 were identified by the Relativity Assessment Workgroup through the Codes Reported Together 75% or More Screen. These codes are billed commonly with 95904. In February 2011, the specialties submitted a code change proposal to the CPT Editorial Panel to bundle the services commonly reported together. The Panel created three new ZZZ global codes to be reviewed at the RUC in April 2011. The CPT Editorial Panel noted, and the RUC agreed, that these three new codes were approved with the intent that the specialties will take additional time and bring forward a more comprehensive coding solution which bundles services commonly performed together during the CPT 2013 cycle.

95885 *Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited*

The RUC reviewed the survey results from 88 physicians for CPT code 95885. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. The RUC reviewed CPT code 92621 *Evaluation of central auditory function, with report; each additional 15 minutes* (work RVU= 0.35) and agreed that the two services have comparable physician work and intensity with identical intra-service time of 15 minutes. Given this, the RUC recommends the work value for 95885 be directly crosswalked to the reference code's work RVU of 0.35. To further justify this value, the RUC reviewed another reference code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete* (work RVU= 0.38) and agreed that these two analogous services have identical intra-service time, 15 minutes, and should be valued similarly. **The RUC recommends a work RVU of 0.35 for CPT code 95885.**

95886 *Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels*

The RUC reviewed the survey results from 74 physicians for CPT code 95886. The RUC reviewed the survey's estimated work values and agreed with the specialties that the respondents overestimated the work value of this service. The RUC reviewed the reference code 95973 *Electronic analysis of implanted neurostimulator pulse generator system; complex spinal cord, or peripheral (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour* (work RVU= 0.92) and agreed that the two services have similar physician work and intensity with identical intra-service time of 30 minutes. Given this, the RUC recommends the work value for 95886 be directly crosswalked to the reference code's work RVU of 0.92. To further justify this value, the RUC reviewed the reference code 17315 *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) (work RVU= 0.87) and agreed that while the two services have identical intra-service time of 30 minutes, the surveyed code is a more complex procedure and should be valued slightly higher than the reference code. **The RUC recommends a work RVU of 0.92 for CPT code 95886.**

95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study

The RUC reviewed the survey results from 63 physicians for CPT code 95887. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. The RUC reviewed the reference code 88334 *Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site* (work RVU= 0.73) and agreed that the two services have similar physician work and identical intra-service time of 20 minutes. Given the similarities, the RUC recommends the work value for 95887 be directly crosswalked to the reference code's work RVU of 0.73. To further justify this value, the RUC reviewed reference code 76885 *Ultrasound, infant hips, real time with imaging documentation; dynamic (requiring physician manipulation)* (work RVU= 0.74) and agreed that the two services have comparable physician work and intensity with identical intra-service time of 20 minutes. **The RUC recommends a work RVU of 0.73 for CPT code 95887.**

95900 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

The RUC reviewed the survey results from 64 physicians for CPT code 95900. The RUC recommends maintaining the current RUC reviewed pre-service time of 4 minutes, intra-service time of 6 minutes and post-service time of 4 minutes. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. Given that there is no compelling evidence to suggest the physician work has changed for this service, the RUC recommends the current work RVU of 0.42 for this service. To justify this value, the RUC looked at the MPC code 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU= 0.48) and agreed that these service are comparable but given that the reference code has great intra-service time, 10 minutes compared to 6 minutes, the surveyed code should be valued lower. **The RUC recommends a work RVU of 0.42 for CPT code 95900.**

95903 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, motor, with F-wave study

The RUC reviewed the survey results from 64 physicians for CPT code 95903. The RUC recommends pre-service time of 4 minutes, intra-service time of 10 minutes and post-service time of 4 minutes. The pre-service and post-service time components were reduced from the survey median values to match the analogous physician work of 95900. The RUC noted there is no compelling evidence to suggest the physician work has changed for this service and recommends the current work RVU of 0.60 for this code. To justify this value, the RUC looked at the key reference service 95937 *Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method* (work RVU= 0.65) and agreed that these services have analogous physician work and intensity. The RUC determined that 95937 has greater intra-service time compared to the surveyed code, 12 minutes and 10 minutes, respectively, therefore the surveyed code should be valued slightly less. Finally, the RUC noted that the current work RVU of 0.60 is supported by the survey's 25th percentile at the same value. **The RUC recommends a work RVU of 0.60 for CPT code 95903.**

95904 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, motor, sensory

The RUC reviewed the survey results from 66 physicians for CPT code 95904. The RUC recommends maintaining the current RUC reviewed pre-service time of 4 minutes, intra-service time of 5 minutes and post-service time of 3 minutes. The RUC reviewed the survey work values and agreed with the specialties that the respondents overestimated the work value of this service. Given that there is no compelling evidence to suggest the physician work has changed for this service, the RUC recommends the current work RVU of 0.34 for this service. To justify this value, the RUC reviewed CPT code 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination* (work RVU= 0.30) and agreed that since the surveyed code has greater total time than the reference code, 12 minutes compared to 10 minutes, 95904 should be valued slightly higher than the reference code. **The RUC recommends a work RVU of 0.34 for CPT code 95904.**

Work Neutrality

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

Practice Expense

The RUC had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. The direct inputs recommended by the specialty for codes 95900, 95903, and 95904 were not accepted and the existing inputs are to be maintained. In addition, the RUC recommended the codes be sent to CPT for revision. For all other codes the clinical labor was specifically refined to reflect the work of the evaluation and management service typically performed prior to these services. Supplies and equipment were also reviewed carefully and modified where appropriate.

Additional Discussion

The RUC affirmed that the valuation for CPT codes 95900, 95903 and 95904 is appropriate given the current survey data and review. However, if the specialty should obtain compelling evidence through additional data sources they should not be precluded from requesting a review of these services (i.e. Five-Year Review).

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Medicine Neurology and Neuromuscular Procedures Electromyography</p> <p>Needle electromyographic (EMG) procedures include the interpretation of electrical waveforms measured by equipment that produces both visible and audible components of electrical signals recorded from the muscle(s) studied by the needle electrode.</p> <p><u>Use 95870 or 95885 when four or fewer muscles are tested in an extremity. Use 95860-95864 or 95886 when five or more muscles are tested in an extremity.</u></p> <p><u>Use EMG codes (95860-95864 and 95867-95870) when no nerve conduction studies (95900-95904) are performed on that day. Use 95885, 95886 and 95887 for EMG services when nerve conduction studies (95900-95904) are performed in conjunction with EMG on the same day.</u></p> <p><u>Report either 95885 or 95886 once per extremity. Codes 95885 and 95886 can be reported together up to a combined total of four units of service per patient when all four extremities are tested.</u></p>				
#● +95885	GG1	Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)	ZZZ	0.35
#● +95886	GG2	<p>complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)</p> <p>(Use 95885, 95886 in conjunction with 95900-95904)</p> <p>(Do not report 95885, 95886 in conjunction with 95860-95864, 95870, 95905)</p>	ZZZ	0.92
#● +95887	GG3	<p>Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)</p> <p>(Use 95887 in conjunction with 95900-95904)</p> <p>(Do not report 95887 in conjunction with 95867-95870, 95905)</p>	ZZZ	0.73

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine Neurology and Neuromuscular Procedures Nerve Conduction Tests				
E ⊙95900	GG4	Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study	XXX	0.42 (No Change)
E ⊙95903	GG5	motor, with F-wave study	XXX	0.60 (No Change)
E ⊙95904	GG6	sensory (Report 95900, 95903, and/or 95904 only once when multiple sites on the same nerve are stimulated or recorded) (Use 95885-95887 in conjunction with 95900-95904 when performing <u>electromyography with nerve conduction studies</u>)	XXX	0.34 (No Change)
E ⊙95905	GG7	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report (Report 95905 only once per limb studied) (Do not report 95905 in conjunction with <u>95885, 95886, 95900-95904, 95934-95936</u>)	XXX	N/A

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

CPT Code: 95885 Tracking Number GG1

Original Specialty Recommended RVU: **0.34**Presented Recommended RVU: **0.35**

Global Period: ZZZ

RUC Recommended RVU: **0.35**

CPT Descriptor: Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year old woman has a five month history of frequent awakening at night due to right hand and arm pain. Prolonged typing also causes distal right upper extremity numbness, tingling and pain and she sometimes drops things out of the right hand. Physical examination reveals numbness of the palmar aspects of the right index and middle fingers; and a questionable Tinel's sign over the right median nerve at the carpal tunnel. Three motor and four sensory nerve conduction studies were performed. Right median sensory nerve conduction is slowed across the carpal tunnel. Needle electromyography examination of a thenar muscle innervated by the median nerve of the symptomatic limb is indicated, along with an ulnar and radial-innervated muscle to confirm the diagnosis of median neuropathy at the wrist, evaluate severity, and rule out more widespread pathology.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 3%

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? 2%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the needle EMG test with the patient and answering questions regarding the pain associated with the procedure. The physician must specifically assess the risk of the procedure (e.g., bleeding, infection) by reviewing the patient's medical history and medications. The physician places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode into each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to insure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Four or fewer muscles are

examined individually using the steps outlined above. The muscles are located in an upper or lower extremity and its related cervical or lumbar paraspinal areas.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Kevin Kerber, MD and Marianna Spanaki, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD and Andrea Boon, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)				
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA				
CPT Code:	95885				
Sample Size:	480	Resp N:	88	Response: 18.3 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	50.00	175.00	478.00
Survey RVW:		0.37	0.90	1.50	2.00
Pre-Service Evaluation Time:				7.50	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		4.00	15.00	22.50	40.00
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
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:	95885	Recommended Physician Work RVU: 0.35		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		15.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95861	XXX	1.54	RUC Time

CPT Descriptor Needle electromyography; 2 extremities with or without related paraspinal areas**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36405	XXX	0.31	RUC Time	1

CPT Descriptor 1 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	19,660,131

CPT Descriptor 2 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.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 42 % of respondents: 47.7 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95885	<u>Key Reference CPT Code:</u> 95861	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	15.00	
Median Intra-Service Time	15.00	25.00	
Median Immediate Post-service Time	0.00	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	15.00	50.00
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	3.64	3.71
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.55	3.52
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Urgency of medical decision making	3.14	3.21
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.17	4.19
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Physical effort required	3.21	3.29
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.52	2.62
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Outcome depends on the skill and judgment of physician	4.19	4.19
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Estimated risk of malpractice suit with poor outcome	2.57	2.71
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INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.81	2.81
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Intra-Service intensity/complexity	3.86	3.93
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Post-Service intensity/complexity	3.07	3.05
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Additional Rationale and Comments

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

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations.

Please explain the rationale for this estimate. This is based on the 2009 Medicare utilization of CPT code 95870, though a small percentage of 95870 will continue to be reported as stand-alone EMGs.

Specialty Neurology	Frequency 42102	Percentage 68.71 %
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Specialty PM&R	Frequency 15862	Percentage 25.88 %
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Specialty Physical Therapy	Frequency 141	Percentage 0.23 %
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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

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. 95870

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

CPT Code:95886 Tracking Number GG2

Original Specialty Recommended RVU: **0.90**Presented Recommended RVU: **0.92**

Global Period: ZZZ

RUC Recommended RVU: **0.92**

CPT Descriptor: Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels

(List separately in addition to code for primary procedure)

(Use 95885, 95886 in conjunction with 95900-95904)

(Do not report 95885, 95886 in conjunction with 95860-95864, 95870, 95905)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55 year old diabetic man has a two month history of pain, numbness, and tingling of the left upper extremity. There was no preceding injury and there are no clear cut provocative or palliative factors. Physical examination reveals no definite motor, sensory or reflex abnormalities. Three motor and four sensory nerve conduction studies were performed. No abnormalities are noted on these studies. Needle electromyography examination of at least 1 muscle innervated by the C5, C6, C7, C8, and T1 spinal roots in the symptomatic limb, and cervical paraspinal muscles at 1 or more levels, is indicated to evaluate for mononeuropathy, peripheral neuropathy, brachial plexopathy, or cervical radiculopathy as a cause for these symptoms.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 2%

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? 1%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the needle EMG test with the patient and answering questions regarding the pain associated with the procedure. The physician must specifically assess the risk of the procedure (e.g., bleeding, infection) by reviewing the patient's medical history and medications. The physician places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode into each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration,

amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to insure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Five or more muscles are examined individually using the steps outlined above. The muscles are located in an upper or lower extremity and its related cervical or lumbar paraspinal areas, and are innervated by three or more nerves or four or more spinal levels.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	Kevin Kerber, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD and Andrea Boon, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)					
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA					
CPT Code:	95886					
Sample Size:	481	Resp N:	74	Response: 15.3 %		
Sample Type:	Panel	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	150.00	250.00	500.00	2200.00
Survey RVW:		0.48	1.20	1.54	2.38	6.30
Pre-Service Evaluation Time:				9.50		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		8.00	20.00	30.00	45.00	65.00
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:

ZZZ Global Code

CPT Code:	95886	Recommended Physician Work RVU: 0.92				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		30.00				
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95861	XXX	1.54	RUC Time

CPT Descriptor Needle electromyography; 2 extremities with or without related paraspinal areas**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11100	000	0.81	RUC Time	2,579,687

CPT Descriptor 1 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99202	XXX	0.93	RUC Time	2,352,028

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded 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 of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 36 % of respondents: 48.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95886	<u>Key Reference CPT Code:</u> 95861	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	15.00	
Median Intra-Service Time	30.00	25.00	
Median Immediate Post-service Time	0.00	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	30.00	50.00
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	4.31	4.17
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.19	4.08
--	------	------

Urgency of medical decision making	3.69	3.67
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.50	4.33
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Physical effort required	3.28	3.25
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.22	3.17
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Outcome depends on the skill and judgment of physician	4.56	4.44
--	------	------

Estimated risk of malpractice suit with poor outcome	3.00	2.97
--	------	------

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.36	3.39
----------------------------------	------	------

Intra-Service intensity/complexity	4.33	4.28
------------------------------------	------	------

Post-Service intensity/complexity	3.47	3.50
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Additional Rationale and Comments

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

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations.

Specialty Neurology	Frequency 407552	Percentage 63.00 %
Specialty PM&R	Frequency 194075	Percentage 30.00 %
Specialty Physical Therapy	Frequency 4974	Percentage 0.76 %

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

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. 95860

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

CPT Code:95887 Tracking Number GG3

Original Specialty Recommended RVU: **0.48**Presented Recommended RVU: **0.73**

Global Period: ZZZ

RUC Recommended RVU: **0.73**

CPT Descriptor: Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)

(Use 95887 in conjunction with 95900-95904)

(Do not report 95887 in conjunction with 95867-95870, 95905)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old woman has a two month history of right facial weakness involving the forehead, eyelid and mouth. Initially she was treated with steroids for a presumptive diagnosis of Bell's palsy, but her deficits persisted. Physical examination demonstrates a peripheral distribution right facial palsy. Right facial motor nerve conduction study was abnormal due to prolonged distal motor latency and low compound muscle action potential amplitude. Needle electromyography of right cranial nerve innervated muscles (V, VII, XI, XII) is indicated to confirm the diagnosis, help establish the prognosis and determine the need for facial nerve decompression.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 3%

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? 1%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the needle EMG test with the patient and answering questions regarding the pain associated with the procedure. The physician must specifically assess the risk of the procedure (e.g., bleeding, infection) by reviewing the patient's medical history and medications. The physician places the ground surface electrode, cleans the skin overlying anticipated muscle puncture sites, and dons gloves prior to the examination. Prior to inserting the needle electrode into each muscle to be examined, the electromyographer must perform a focused physical examination to determine surface anatomic landmarks, and identify structures to avoid during the needle insertion. Under minimal voluntary contraction of the muscle at least 20 voluntary motor unit potentials are analyzed along multiple passes through the muscle, noting duration, amplitude, configuration and other diagnostic variables both visually and by sound that allow the waveform to be classified as normal or abnormal. The patient is examined after the needle is withdrawn from each puncture site to insure hemostasis and to apply any needed manual pressure or bandage where minor bleeding may be observed. Cranial nerve innervated

muscles (eg, face or tongue muscles) or axial muscles (eg, serratus anterior or thoracic paraspinal muscles) on one side of the body are examined individually using the steps outlined above. Special care must be taken during the study since many muscles are thin and located adjacent to critical structures (eg, eye or lung).

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	Kevin Kerber, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD and Andrea Boon, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)					
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA					
CPT Code:	95887					
Sample Size:	482	Resp N:	63	Response: 13.0 %		
Sample Type:	Panel	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	5.00	10.00	25.00	1000.00
Survey RVW:		0.48	0.81	1.20	1.73	3.30
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		5.00	15.00	20.00	30.00	60.00
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:

ZZZ Global Code

CPT Code:	95887	Recommended Physician Work RVU: 0.73				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

KEY REFERENCE SERVICE:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95861	XXX	1.54	RUC Time

CPT Descriptor Needle electromyography; 2 extremities with or without related paraspinal areas**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36405	XXX	0.31	Harvard Time	1

CPT Descriptor 1 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	19,660,131

CPT Descriptor 2 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.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 29 % of respondents: 46.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95887	<u>Key Reference CPT Code:</u> 95861	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	15.00	
Median Intra-Service Time	20.00	25.00	
Median Immediate Post-service Time	0.00	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	20.00	50.00
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	4.52	4.31
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.52	4.28
Urgency of medical decision making	4.17	3.93

Technical Skill/Physical Effort (Mean)

Technical skill required	4.90	4.62
Physical effort required	3.62	3.52

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.79	3.28
Outcome depends on the skill and judgment of physician	4.86	4.66
Estimated risk of malpractice suit with poor outcome	3.59	3.21

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.69	3.52
Intra-Service intensity/complexity	4.48	4.52
Post-Service intensity/complexity	3.79	3.66

Additional Rationale and Comments

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

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations.

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 12,573 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on 2009 Medicare utilization of 95867, 95868, and 95869, though a small percentage of those services will continue to be reported as stand-alone EMGs.

Specialty Neurology	Frequency 9849	Percentage 78.33 %
Specialty PM&R	Frequency 1835	Percentage 14.59 %
Specialty Physical Therapy	Frequency 28	Percentage 0.22 %

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

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. 95860

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

CPT Code: 95900 Tracking Number GG4

Original Specialty Recommended RVU: **0.42**

Global Period: XXX

Presented Recommended RVU: **0.42**RUC Recommended RVU: **0.42**

CPT Descriptor: Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female presents to the clinic with weakness of the right quadriceps muscle and pain over the right hip. Based on the examination, a traumatic femoral neuropathy is suspected. A motor nerve conduction study without f-wave of the right femoral nerve is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 1%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical questions. Specifically the physician considers available recording and stimulating sites for the nerve, and determining the appropriate sites based on the possible sites of nerve injury. The appropriate muscles to be studied are then determined.

Description of Intra-Service Work: Intra-service work includes physician performance or supervision of patient preparation, placement of ground, stimulating and recording surface electrodes, stimulation of nerves and recording of the waveform of the resulting compound muscle action potentials. The waveform is analyzed with respect to latency, amplitude and configuration. Interelectrode distances are measured and recorded. Test design changes during the course of the study in response to the information obtained.

Description of Post-Service Work: Post-service work involves calculation of nerve conduction velocities, comparison to normal values, summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and sometimes suggestions for further work-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Kevin Kerber, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)				
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA				
CPT Code:	95900				
Sample Size:	485	Resp N:	64	Response: 13.1 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	20.00	245.00	1050.00
Survey RVW:		0.18	0.50	0.65	1.10
Pre-Service Evaluation Time:				10.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		3.00	5.00	10.00	15.00
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:	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:

Select Pre-Service Package

CPT Code:	95900	Recommended Physician Work RVU: 0.42		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		4.00	0.00	4.00
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:		6.00		
Immediate Post Service-Time:		4.00		
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95937	XXX	0.65	RUC Time

CPT Descriptor Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36405	XXX	0.31	RUC Time	1

CPT Descriptor 1 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	19,660,131

CPT Descriptor 2 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.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 25 % of respondents: 39.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95900	<u>Key Reference CPT Code:</u> 95937	<u>Source of Time</u> RUC Time
Median Pre-Service Time	4.00	5.00	
Median Intra-Service Time	6.00	12.00	
Median Immediate Post-service Time	4.00	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	14.00	0.00
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	4.16	4.16
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	4.12
Urgency of medical decision making	3.96	4.12

Technical Skill/Physical Effort (Mean)

Technical skill required	4.24	4.40
Physical effort required	3.40	3.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.80	2.80
Outcome depends on the skill and judgment of physician	4.52	4.48
Estimated risk of malpractice suit with poor outcome	2.84	3.00

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.48	3.68
Intra-Service intensity/complexity	4.04	4.16
Post-Service intensity/complexity	3.48	3.52

Additional Rationale and Comments

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

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations. While the survey data showed higher times and RVWs, the panel felt there was not evidence

Specialty Physical Therapy

Frequency 8500

Percentage 0.61 %

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 95900

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: 95903 Tracking Number GG5

Original Specialty Recommended RVU: **0.60**Presented Recommended RVU: **0.60**

Global Period: XXX

RUC Recommended RVU: **0.60**

CPT Descriptor: Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old woman presents with 3 months of weakness and numbness of her arms and legs. Physical examination shows weakness of distal upper and lower limb muscles, areflexia and sensory loss. Axonal or demyelinating polyneuropathies are suspected. Motor nerve conduction studies with f-waves in the upper and lower limbs are indicated.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 1%

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? 1%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical questions. Specifically the physician considers available recording and stimulating sites for the nerve, and determining the appropriate sites based on the possible sites of nerve injury. The appropriate muscles to be studied are then determined

Description of Intra-Service Work: Intra-service work includes physician performance or supervision of patient preparation, placement of ground, stimulating and recording surface electrodes, stimulation of nerves and recording of the waveform of the resulting compound muscle action potentials. The waveform is analyzed with respect to latency, amplitude and configuration. Interelectrode distances are measured and recorded. F-wave studies involve changing the electromyograph's gain setting, time base and filter settings (sometimes), reorienting the stimulating electrode (sometimes) and stimulating motor nerves enough times to generate more than 10 F-waves, which are recorded and analyzed. Test design changes during the course of the study in response to the information obtained.

Description of Post-Service Work: Post-service work involves calculation of nerve conduction velocities, sometimes calculation of certain F-wave indices that are more sensitive than raw F-wave latencies, comparison to normal values, summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and sometimes suggestions for further work-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Kevin Kerber, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)				
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA				
CPT Code:	95903				
Sample Size:	481	Resp N:	65	Response: 13.5 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	100.00	360.00	1000.00
Survey RVW:		0.25	0.60	0.78	1.38
Pre-Service Evaluation Time:				8.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		4.00	8.00	15.00	30.00
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
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:

Select Pre-Service Package

CPT Code:	95903	Recommended Physician Work RVU: 0.60		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		4.00	0.00	4.00
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:		4.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95937	XXX	0.65	RUC Time

CPT Descriptor Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	19,660,131

CPT Descriptor 1 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.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99462	XXX	0.62	RUC Time	15

CPT Descriptor 2 Subsequent hospital care, per day, for evaluation and management of normal newborn

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 27 % of respondents: 41.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95903	<u>Key Reference CPT Code:</u> 95937	<u>Source of Time</u> RUC Time
Median Pre-Service Time	4.00	5.00	
Median Intra-Service Time	10.00	12.00	
Median Immediate Post-service Time	4.00	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	18.00	22.00
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	4.41	4.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	4.30
Urgency of medical decision making	4.04	4.04

Technical Skill/Physical Effort (Mean)

Technical skill required	4.41	4.56
Physical effort required	3.67	3.81

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.19	3.07
Outcome depends on the skill and judgment of physician	4.63	4.56
Estimated risk of malpractice suit with poor outcome	3.22	3.19

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.59	3.67
Intra-Service intensity/complexity	4.19	4.30
Post-Service intensity/complexity	3.70	3.74

Additional Rationale and Comments

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

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations. While the survey data showed higher times and RVWs, the panel felt there was not evidence

Specialty Physical Therapy

Frequency 11750

CPT Code: 95903
Percentage 0.54 %

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 95903

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:95904 Tracking Number GG6

Original Specialty Recommended RVU: **0.34**Presented Recommended RVU: **0.34**

Global Period: XXX

RUC Recommended RVU: **0.34**

CPT Descriptor: Nerve conduction, amplitude and latency/velocity study, each nerve; sensory
(Report 95900, 95903, and/or 95904 only once when multiple sites on the same nerve are stimulated or recorded)
(Use 958XX-958ZZ with 95900-95904 when performing electromyography with nerve conduction studies)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45 year woman with no significant past medical history presents with three months of tingling and numbness in both lower limbs distally and in the left more than right hand. Physical examination shows normal strength, loss of pin prick and vibration over the feet, lower legs, and fingers bilaterally, as well as absent ankle reflexes. A disorder affecting sensorimotor nerves or a neuropathy is suspected. Motor nerve conduction studies show normal distal lower and upper limb nerve conduction values. Sensory nerve conduction studies are recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 1%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the medical records, takes a brief history and performs a brief examination. These steps are necessary to ensure that the test is performed in a way that addresses the relevant clinical questions. Specifically the physician considers available recording and stimulating sites for the nerve, and determining the appropriate sites based on the possible sites of nerve injury. The appropriate muscles to be studied are then determined.

Description of Intra-Service Work: Intra-service work includes physician participation in patient preparation, focusing on discussing the test with the patient and answering questions regarding the pain associated with the procedure. After identifying anatomic landmarks, the physician (and/or the technologist) cleans the skin overlying anticipated nerve stimulation and recording sites and places the recording electrodes and ground surface electrodes. Electrical stimuli are delivered via the surface stimulating electrode prongs; this includes searching for the optimal site by the obtained response, rotating the prongs to secure the proper shape of waveform on the EMG machine screen, and constantly communicating with the patient in an effort to reduce muscle artifact. Reporting procedures are explained to the patient.

Description of Post-Service Work: Post-service work involves assessing the waveforms from each sensory nerve tested, summarization of clinical and electrodiagnostic data, writing the physician interpretation, generation of a differential diagnosis, and sometimes providing suggestions for further investigations.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Kevin Kerber, MD (AAN); Marc Nuwer, MD, PhD (ACNS); Benn Smith, MD (AANEM); John Palazzo, DSc, PT, ECS (APTA)				
Specialty(s):	AAN, AANEM, AAPM&R, ACNS, APTA				
CPT Code:	95904				
Sample Size:	484	Resp N:	66	Response: 13.6 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	300.00	800.00	2000.00
Survey RVW:		0.16	0.40	0.59	1.18
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	5.00	10.00	20.00
Immediate Post Service-Time:		<u>10.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:	95904	Recommended Physician Work RVU: 0.34		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		4.00	0.00	4.00
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:		<u>3.00</u>		
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95937	XXX	0.65	RUC Time

CPT Descriptor Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
36405	XXX	0.31	RUC Time	1

CPT Descriptor 1 Venipuncture, younger than age 3 years, necessitating physician's skill, not to be used for routine venipuncture; scalp vein

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	19,660,131

CPT Descriptor 2 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.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 34.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95904	<u>Key Reference CPT Code:</u> 95937	<u>Source of Time</u> RUC Time
Median Pre-Service Time	4.00	5.00	
Median Intra-Service Time	5.00	12.00	
Median Immediate Post-service Time	3.00	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	12.00	22.00
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	4.26	4.30
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.26	4.48
Urgency of medical decision making	4.13	4.22

Technical Skill/Physical Effort (Mean)

Technical skill required	4.43	4.57
Physical effort required	3.57	3.74

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.13	3.13
Outcome depends on the skill and judgment of physician	4.61	4.57
Estimated risk of malpractice suit with poor outcome	3.26	3.17

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.91	3.91
Intra-Service intensity/complexity	4.13	4.30
Post-Service intensity/complexity	3.83	3.91

Additional Rationale and Comments

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

A consensus panel representing members of each of the 5 surveying specialties met via conference call and email to develop recommendations. While the survey data showed higher times and RVWs, the panel felt there was not evidence

Specialty Physical Therapy

Frequency 21932

Percentage 0.60 %

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 95904

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

CPT Long Descriptor:

95885 Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; limited (List separately in addition to code for primary procedure)

Global Period: ZZZ

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 representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

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

The panel looked at existing PE inputs for a similar service (95870) as a basis for the new code, and modified them to reflect current PE Subcommittee conventions.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No pre-service time as the code is an add-on.

Intra-Service Clinical Labor Activities:

The additional components of the EMG test are explained to the patient, and the patient is asked if they wish to proceed. The patient's medical history is reviewed so that the risks of the procedure (eg, bleeding or pain) can be properly assessed. Notes are taken during the test regarding the results.

Post-Service Clinical Labor Activities:

No pre-service time as the code is an add-on.

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

CPT Long Descriptor:

95886 Needle electromyography, each extremity with related paraspinal areas when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)

Global Period: ZZZ

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 representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

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

The panel looked at existing PE inputs for a similar service (95860) as a basis for the new code, and modified them to reflect current PE Subcommittee conventions.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No pre-service time as the code is an add-on.

Intra-Service Clinical Labor Activities:

The additional components of the EMG test are explained to the patient, and the patient is asked if they wish to proceed. The patient's medical history is reviewed so that the risks of the procedure (eg, bleeding or pain) can be properly assessed. Notes are taken during the test regarding the results.

Post-Service Clinical Labor Activities:

No pre-service time as the code is an add-on.

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

CPT Long Descriptor:

95887 Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)

Global Period: ZZZ

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 representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

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

The panel looked at existing PE inputs for similar services (95867, 95869, and 95870) as a basis for the new code, and modified them to reflect current PE Subcommittee conventions.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

No pre-service time as the code is an add-on.

Intra-Service Clinical Labor Activities:

The additional components of the EMG test are explained to the patient, and the patient is asked if they wish to proceed. The patient's medical history is reviewed so that the risks of the procedure (eg, bleeding or pain) can be properly assessed. Notes are taken during the test regarding the results.

Post-Service Clinical Labor Activities:

No pre-service time as the code is an add-on.

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

CPT Long Descriptor:

Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Global Period: XXX

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

A consensus panel representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

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

The panel looked at existing PE inputs for the service as approved in 1999 and modified them to reflect current PE Subcommittee conventions and current typical inputs for the service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Intra-Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information).

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area. The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers. Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

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

CPT Long Descriptor:

95903 Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study

Global Period: XXX

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

A consensus panel representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

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

The panel looked at existing PE inputs for the service as approved in 2000 and modified them to reflect current PE Subcommittee conventions and current typical inputs for the service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Intra-Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information).

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area. The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers. Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record or mailed to the outside referring physician.

AMA Specialty Society RVS Update Committee Recommendation

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

CPT Long Descriptor:

95904 Nerve conduction, amplitude and latency/velocity study, each nerve; sensory

Global Period: XXX

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

A consensus panel representing members from each of the 5 surveying specialties met via email and conference call to develop recommendations.

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

The panel looked at existing PE inputs for the service as approved in 1999 and modified them to reflect current PE Subcommittee conventions and current typical inputs for the service.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

The patient is called prior to the test day to confirm the appointment and answer questions. The patient is greeted by the technician, identity verified by full name and date of birth, and escorted into the room where testing is to be done.

Intra-Service Clinical Labor Activities:

The medical record and all documents related to the testing are read, allowing the plan of electrodiagnostic testing unique to the patient to be formulated. The test is explained to the patient, consent is obtained, and the patient is asked if they wish to proceed. The technician prepares the room, changes the exam table paper/linen, and reviews the supplies to be sure that the necessary equipment is available in the room. The patient information is entered into the EMG machine via keyboard including name, medical record number, gender, height, weight, and codified medical history, including indications for testing. The patient is instructed to disrobe, and don a gown. The patient is covered with a blanket and then the limb temperatures are measured using a temperature probe because a threshold temperature is required for an optimal test. The limb is warmed for up to 10 minutes as appropriate to attain the required temperature level. Notes are taken during the test regarding the results and other information (eg, temperature of the limb at the time of the test, presence of peripheral edema, other relevant clinical information).

Post-Service Clinical Labor Activities:

The patient is monitored after the procedure for any adverse effects. Patient questions are answered. When necessary the patient is assisted with re-dressing and is escorted back to the patient waiting area. The room is cleaned and soiled/disposable linens and other materials are placed in the proper containers. Forms/data sheets are printed, collected, and brought to the administrative/interpretation area. After the report is finalized, it is uploaded to the electronic medical record and/or mailed/faxed to the outside referring physician.

	A	B	C	D	E	F
1				95900	95903	95904
	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation RECOMMENDATION TO MAINTAIN EXISTING DIRECT PE INPUTS			Nerve conduction,...; motor, without F- wave study	Nerve conduction,...; motor, with F- wave study	Nerve conduction, ..., each nerve; sensory
2		CMS	Staff			
3	LOCATION	Code	Type	Non Facility	Non Facility	Non Facility
4	GLOBAL PERIOD	L037A	Electrodx Tec	XXX	XXX	XXX
5	TOTAL CLINICAL LABOR TIME			24.0	30.0	24.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			24.0	30.0	24.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			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	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					
29	Assist physician in performing procedure					
32	Post-Service					
33	Monitor pt. following service/check tubes, monitors, drains					
34	Clean room/equipment by physician staff					
35	Clean and sterilize electrodes.					
36	Complete medical record, and archive data.					
39	Complete diagnostic forms, lab & X-ray requisitions					
44	End: Patient leaves office					
45	POST-SERVICE Period					
46	Start: Patient leaves office/facility					
47	Conduct phone calls/call in prescriptions					
58	End: with last office visit before end of global period					

	A	B	C	D	E	F
1				95900	95903	95904
2	Meeting Date: April 2011 AMA Specialty Society RVS Update Committee Recommendation RECOMMENDATION TO MAINTAIN EXISTING DIRECT PE INPUTS			Nerve conduction,...; motor, without F-wave study	Nerve conduction,...; motor, with F-wave study	Nerve conduction, ..., each nerve; sensory
3	LOCATION	Code	Type	Non Facility	Non Facility	Non Facility
59	MEDICAL SUPPLIES	Code				
62	electrode, bar-style (single)	SD052			1	
63	electrode, ground	SD059		1	1	1
64	drape, non-sterile, sheet 40in x 60 in	SB006		1	1	1
65	gloves, non-sterile	SB022		2	2	1
66	gown, patient	SB026		1	1	1
67	paper, exam table	SB036		7	7	7
68	paper, recording (per sheet)	SK059		1	1	
69	electrode conductive gel	SJ020		5	5	5
70	swab-pad, alcohol	SJ053		2	2	2
72	gauze, sterile 4in x 4in	SG055		2	2	2
73	tape, surgical paper 1in (Micropore)	SG079		6	6	6
76	measuring tape, paper	SK048		1	1	1
77	electrode skin prep gel (NuPrep)	SJ022		100	100	100
78	povidone soln (Betadine)	SJ041		1	10	1
79	sensor strip, skin temperature	SJ045		1	1	1
80	Equipment					
81	table, exam	EF023		24	30	24
82	hydrocollator, hot	EQ130		24		24
83	EMG-NCV-EP system 8 channel	EQ024		24	30	24
85						
86						

	A	B	C	E
1	AMA Specialty Society RVS Update Committee Recommendation			95887
2	Meeting Date: April 2011 Specialty: AAN, AANEM, ACNS, AAPMR, APTA	CMS	Staff	Needle EMG, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study
3	LOCATION	Code	Type	Non Facility
4	GLOBAL PERIOD	L037A	Electrodx Tec	ZZZ
5	TOTAL CLINICAL LABOR TIME			13.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			13.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			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	Greet patient, provide gowning, ensure appropriate medical records are available			
21	Obtain vital signs			
22	Provide pre-service education/obtain consent			0
23	Prepare room, equipment, supplies			0
24	Setup scope (non facility setting only)			
25	Setup machine			0
26	Prepare and position patient/ monitor patient/ set up IV			0
27	Sedate/apply anesthesia			
28	Intra-service			
29	Prepare skin - clean each insertion site with alcohol			0
30	Assist physician in performing procedure			10
31	Monitor pt. to ensure they stop bleeding; apply gauze			3
32	Release patient. Give discharge instructions.			0
33	Post-Service			
34	Monitor pt. following service/check tubes, monitors, drains			
35	Clean room/equipment by physician staff			0
36	Clean Scope			
37	Clean Surgical Instrument Package			
38	Complete diagnostic forms, lab & X-ray requisitions			
39	Review/read X-ray, lab, and pathology reports			
40	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions			
41	Discharge day management			
43	End: Patient leaves office			
44	POST-SERVICE Period			
45	Start: Patient leaves office/facility			
46	Conduct phone calls/call in prescriptions			
57	End: with last office visit before end of global period			

	A	B	C	E
1	AMA Specialty Society RVS Update Committee Recommendation			95887
2	Meeting Date: April 2011 Specialty: AAN, AANEM, ACNS, AAPMR, APTA	CMS	Staff	Needle EMG, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study
3	LOCATION	Code	Type	Non Facility
58	MEDICAL SUPPLIES	Code		
59	electrode needle, concentric EMG w-lead	SD049		1
62	electrode, ground	SD059		1
63	electrode, EEG (single)	SD165		1
64	drape, non-sterile, sheet 40in x 60 in	SB006		0
65	gloves, non-sterile	SB022		0
66	gown, patient	SB026		0
67	paper, exam table	SB036		0
68	paper, recording (per sheet)	SK059		3
69	electrode conductive gel	SJ020		5
70	swab-pad, alcohol	SJ053		4
71	bandage,strip 0.75in x 3in (Bandaid)	SG021		6
72	gauze, sterile 4in x 4in	SG055		4
73	tape, surgical paper 1in (Micropore)	SG079		6
74	pack, minimum multi-speciality visit	SA048		0
75	tape, porous-hypoallergenic 2in (Scanpore)	SG077		0
80	Equipment			
81	table, exam	EF023		26
83	EMG-NCV-EP system 8 channel	EQ024		26
84	EMG-NCV-EP system 2-4 channel	EQ023		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Identified through the Codes Reported Together 75% or More Screen

February and April 2011

Evoked Potentials and Reflex Studies

CPT code pairs 95925/95926 and 95928/95929 were identified by the Relativity Assessment Workgroup Codes Reported Together 75% or More Screen. At the request of the RUC, the specialty societies submitted a coding proposal which was approved by the CPT Editorial Panel to create two bundled codes which will allow providers to report short latency somatosensory evoked potential studies of the upper and lower limbs and central motor evoked potential study of the upper and lower limbs. At the February 2011 RUC meeting, the RUC reviewed the survey results for new codes 95938 and 95939. The specialty had obtained strong, valid survey results for code 95938 but not for 95939, as only 31% of the respondents indicated the vignette was typical. The RUC and specialty societies agreed that a new survey should be conducted and the survey results presented at the April 2011 RUC meeting with an inpatient vignette scenario.

95938 Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs

The RUC reviewed the survey data from 54 neurologists, neuromuscular and electrodiagnostic physicians, physical medicine and rehabilitation physicians and clinical neurophysiological physicians. The specialty societies explained that the survey respondents accurately represented the physician time required to determine the placement and re-placement of electrodes based on responses, to supervise the patient preparation, stimulation of nerves and/or dermatomes and recording the resulting evoked potentials at several sites. The physician reviews the data from hundreds of trials that are conducted as the test design changes during the course of the study in response to the information obtained. To develop a recommended work RVU, the specialties compared the surveyed code to reference code 95927 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head* (work RVU=0.54). The RUC noted that the surveyed code, 95938, requires more total time to perform than the reference code, 95927, 40 minutes and 31.5 minutes, respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment, technical skill and physical effort and overall is a more intense service to perform in comparison to the reference code. The RUC also compared the surveyed code to reference code 78802 *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, single day imaging* (work RVU=0.86). The RUC noted that the surveyed code and the reference code have the same total service time, 40 minutes. Based on these comparisons, the specialty society recommends 0.86 work RVUs, a value halfway between the 25th percentile and the median survey value. Further, the RUC understands that this recommended value represents a 20% savings in work RVUs as this new code represents the bundling of two existing services, 95925 and 95926. **The RUC recommends a work RVU of 0.86 for CPT code 95938.**

95939 Motor evoked potential study; in upper and lower limbs

The RUC reviewed the survey results from 43 physicians who perform these types of services. The RUC agreed with the specialty societies that the survey 25th percentile work RVU of 2.25 appropriately accounts for the physician work required to perform this service. After a review of the survey results and the elimination of the outliers, the specialty recommended 2 additional minutes to the intra-service time for a total intra-service time of 30 minutes and added five minutes to the immediate post service time (15 minutes total) to account for the more time to generate the report from the analyses of four limbs accounting for the assessment of 12 muscles. In addition, this immediate post time is similar to the specialty's key reference code and to the survey results of the distinct services of 95928 and 95929 for which this new code combines. The RUC agreed with that these time adjustments would account for the typical patient scenario. Due to the addition of 95939 to CPT, 95928 and 95959 are expected now to be performed predominately in the outpatient setting. The new combined code would typically be performed in the inpatient setting where the overall number of muscle sites tested is lower, accounting for the lower intra-service time and a much greater level intensity. The existing codes, 95928 and 95929 would continue to shift toward being typically performed in non-facility settings, requiring a greater number of muscle site testing per limb, requiring more intra-service time and physician work.

The RUC compared this new service to the survey's key reference code 95810 *Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by EEG technologist* (work RVU = 2.50, intra-service time = 36.5 minutes). The RUC agreed that while the surveyed code has less intra-service time compared to the reference code, 30 and 36.5 minutes, 95939 was consistently rated by the survey respondents as more difficult through the survey's intensity/complexity measures. The RUC also compared the physician work of 95939 to that of 79403 *Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion* (work RVU = 2.24) and determined that 95939 although the time associated with 79403 was greater, 95939 overall required more skill and had more complexity and intensity per minute than 79403. Further, the RUC understands that the work of this new code accounts for the work of two existing codes, 95928 *Central motor evoked potential study (transcranial motor stimulation); upper limbs* (work RVU = 1.50) and 95929 *Central motor evoked potential study (transcranial motor stimulation); lower limbs* (work RVU = 1.50) (currently billed together 70% of the time in the Medicare population). The creation of this code and its value of 2.25 represents a 25% savings in work RVUs and substantial overall savings to the Medicare system. **The RUC recommends the survey 25th percentile work RVU of 2.25 for CPT code 95939.**

Practice Expense: The RUC carefully reviewed the direct practice expense inputs for 95938 and 95939 in the non-facility setting and made minor edits to the specialty recommendation. In addition, the RUC recommends no direct inputs in the facility setting for this service.

Work Neutrality

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

CPT Code (●New)	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
95925		Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs <u>(Do not report 95925 in conjunction with 95926)</u>	XXX	0.54 (No Change)
95926		in lower limbs <u>(Do not report 95926 in conjunction with 95925)</u>	XXX	0.54 (No Change)
●95938	O1	in upper and lower limbs <u>(Do not report 95938 in conjunction with 95925, 95926)</u>	XXX	0.86
95928		Central motor evoked potential study (transcranial motor stimulation); upper limbs <u>(Do not report 95928 in conjunction with 95929)</u>	XXX	1.50 (No Change)
95929		lower limbs <u>(Do not report 95929 in conjunction with 95928)</u>	XXX	1.50 (No Change)
●95939	O2	in upper and lower limbs <u>(Do not report 95939 in conjunction with 95928, 95929)</u>	XXX	2.25

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

CPT Code:95938 Tracking Number O1

Original Specialty Recommended RVU: **0.86**Presented Recommended RVU: **0.90**

Global Period: XXX

RUC Recommended RVU: **0.86**

CPT Descriptor: Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
(Do not report 95938 in conjunction with 95925, 95926)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 45-year-old woman complains of one month of numbness in her left leg. Three years ago she had an episode of visual blurriness lasting one month, which was not medically evaluated. A four-limb somatosensory evoked potential study (SEP) test was ordered to assess for and localize central conduction impairment, and to separate a central from a peripheral nervous system cause of sensory impairment.

Percentage of Survey Respondents who found Vignette to be Typical: 61%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 26%

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? 13%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The physician reviews the medical records, including history and appropriate neurological examination to establish the questions to be addressed as part of the SEP. Specifically the physician considers the potential anatomic lesions that could cause the clinical manifestations and considers the questions being posed by the referring physician.

Description of Intra-Service Work: Intra-service work includes physician supervision of patient preparation, placement of ground, stimulating and recording surface electrodes, stimulation of nerves and/or dermatomes and recording the resulting evoked potentials at several sites from periphery to cerebral cortex. Many hundreds of trials are averaged since the signals are very small, and each of the 4 limbs is studied successively. Test design changes during the course of the study in response to the information obtained.

Description of Post-Service Work: Post-service work for each of the 4 limbs separately involves determination of the latency and amplitude of the evoked potentials, comparison to normal values, summarization of clinical and electrodiagnostic data, physician interpretation, generation of a differential diagnosis and suggestions for further work-up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	02/2011					
Presenter(s):	Marianna V. Spanaki, MD, PhD (AAN); Joseph P. Zuhosky, MD (AAPMR); William J. Litchy, MD					
Specialty(s):	American Academy of Neurology (AAN), American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), American Academy of Physical Medicine and Rehabilitation (AAPMR), and American Clinical Neurophysiology Society (ACNS)					
CPT Code:	95938					
Sample Size:	130	Resp N:	54	Response: 41.5 %		
Sample Type:	Panel	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	2.00	37.50	115.00	1500.00
Survey RVW:		0.30	0.66	1.07	1.54	160.00
Pre-Service Evaluation Time:				10.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		0.00	10.00	20.00	30.00	300.00
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			
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); 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:	95938	Recommended Physician Work RVU: 0.86		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:	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 0.0	99239x 0.0	
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:	<u>0.00</u>	99224x 0.00	99225x 0.00	99226x 0.00
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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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95927	XXX	0.54	RUC Time

CPT Descriptor Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
20551	000	0.75	RUC Time	201,322

CPT Descriptor 1 Injection(s); single tendon origin/insertion

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
93307	XXX	0.92		7,164,119

CPT Descriptor 2 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 35 % of respondents: 64.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95938	<u>Key Reference CPT Code:</u> 95927	<u>Source of Time</u> RUC Time
Median Pre-Service Time	10.00	6.50	
Median Intra-Service Time	20.00	15.00	
Median Immediate Post-service Time	10.00	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	40.00	31.50
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	3.69	3.54
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.57	3.31
Urgency of medical decision making	3.37	3.00

Technical Skill/Physical Effort (Mean)

Technical skill required	4.03	3.77
Physical effort required	2.69	2.57

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.06	2.83
Outcome depends on the skill and judgment of physician	3.83	3.57
Estimated risk of malpractice suit with poor outcome	3.29	2.94

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.71	2.63
Intra-Service intensity/complexity	3.66	3.31
Post-Service intensity/complexity	3.11	2.86

Additional Rationale and Comments

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

A consensus panel representing members from each of the 4 surveying specialties met via conference call to develop recommendations. The survey received 54 responses. The panel felt the median RVW of 1.07 was too high (representing a value almost equal to the individual RVWs of 95925 and 95926 added together $0.54 + 0.54 = 1.08$). Accounting for some

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
 43,503 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
 Please explain the rationale for this estimate. Based on 2008 Medicare frequency for 95925 and 95926 billed 87% of the
 time together

Specialty Neurology	Frequency 31158	Percentage 32.67 %
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Specialty PM&R	Frequency 3705	Percentage 3.88 %
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Specialty	Frequency	Percentage	%
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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 95925

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:95939 Tracking Number O2 Original Specialty Recommended RVU: **1.75**
Presented Recommended RVU: **2.25**
Global Period: XXX RUC Recommended RVU: **2.25**

CPT Descriptor: Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs
(Do not report 95939 in conjunction with 95928, 95929)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65 year old man has three months of progressive, bilateral lower limb weakness and stiffness. MRI showed severe cervical stenosis with impingement of cervical cord. An anterior and posterior cervical decompression and fusion was planned. A transcranial electrical MEP with four-limb, twelve-muscle recording was performed preoperatively to establish a baseline for use in surgical monitoring.

Percentage of Survey Respondents who found Vignette to be Typical: 77%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 28%

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? 9%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: Review request to determine which muscles to evaluate and special needs to be met during testing. Review history for relative or absolute contraindications. Consult with referring physicians to establish patient testing plan. For a presurgical procedure, alter the muscles tested or scalp stimulation sites as needed for surgery. For a presurgical procedure, discuss sedation or anesthesia constraints with the anesthesiologist.

Description of Intra-Service Work: Insert needle electrodes into left and right biceps, triceps, abductor pollicis brevis, and abductor digiti minimi, medial gastrocnemius, tibialis anterior, and abductor hallucis muscles. Secure electrodes in place. Assure a bite block is comfortably in place. Place 10 scalp recording electrodes at sites measured using the 10-20 electrode placement system. Check impedances, and replace or move electrodes as needed. Prior to performing transcranial brain electrical stimulation, perform routine motor nerve conduction studies of the ulnar and/or median nerves to establish baseline compound muscle action potentials (CMAP). Stimulate at Erb's point and distal nerve segments. Identify evidence of peripheral neuropathy or other pathology interfering with peripheral conduction, and adjust muscles tested to accommodate for those pre-existing disorders. Throughout the brain electrical stimulation procedure, monitor scalp EEG to assess for any epileptic spikes, seizures, or after-discharges that were caused by the electrical brain stimulation. Be prepared abruptly to stop stimulation if it provokes an epileptic seizure, and to care for the patient during any seizure that occurs. Determine the initial scalp location for stimulating electrodes by carefully measuring the head. Stimulate at each of several scalp sites and measure latency and amplitudes of responses at the muscle. Vary the stimulus location to identify

better stimulation locations for this patient. Vary the stimulus voltage intensity at each location in 10% increments to find locations and voltages that produce adequate responses for that muscle. Limit the brain stimulation to 500 volts maximum except in unusual cases. After determining the threshold measure the transcranial MEP amplitude and initial peak latency to establish baseline studies. Adjust the stimulus pulse duration, number of stimuli in a train, and interstimulus interval to identify the best motor responses, while adjusting the voltage as needed. Mark the stimulation sites, and note the voltages, pulse width, train length, and interstimulus intervals needed to obtain optimal responses for that muscle. Replicate data. Store the signals for later review and analysis. Repeat this procedure for 3-4 selected muscles on the same limb. Repeat this procedure on the other upper extremity. Repeat this procedure in the lower extremities. Repeat as need to obtain adequate data. Chart the latency and amplitude findings, measuring latency to the nearest 100 microseconds and amplitude in microvolt units. Comparing the patient's results to normative data adjusted for the patient's individual age, height, and gender. Account for limb temperature. Interpret the pattern of changes, identifying confirmed or suspected sites of pathway disruption due to pathology, and providing a diagnostic interpretation for the results that takes into account the patient's findings, history, exam and prior test and imaging results.

Description of Post-Service Work: Review the diagnostic interpretation and results, eliminate unreliable data, and compare the patient's results to the clinical questions posed for the test. Determine appropriate clinical comments based on the patient's presenting problem and test results. Dictate, review and verify report. Give a verbal report to referring physician if applicable. Respond to any questions from referring physician, or any patient problems.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	Marianna Spanaki, MD, PhD (AAN); Benn Smith, MD and Andrea Boon, MD (AANEM); Marc Nuwer, MD, PhD (ACNS)					
Specialty(s):	AAN, AANEM, AAPMR, ACNS					
CPT Code:	95939					
Sample Size:	131	Resp N:	43	Response: 32.8 %		
Sample Type:	Panel	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	35.00	125.00	275.00	2000.00
Survey RVW:		1.00	2.25	2.50	3.05	5.00
Pre-Service Evaluation Time:				15.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		0.00	20.00	30.00	60.00	360.00
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:	95939	Recommended Physician Work RVU: 2.25		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		15.00	0.00	15.00
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:		15.00		
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95810	XXX	2.50	RUC Time

CPT Descriptor Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99375	XXX	1.73	RUC Time	

CPT Descriptor 1 Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
19445	000	1.78	RUC Time	13,899

CPT Descriptor 2 Application of rigid total contact leg cast

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 9 % of respondents: 20.9 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95939	<u>Key Reference CPT Code:</u> 95810	<u>Source of Time</u> RUC Time
Median Pre-Service Time	15.00	15.00	
Median Intra-Service Time	30.00	36.50	
Median Immediate Post-service Time	15.00	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	60.00	66.50
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	3.89	3.33
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.33	3.78
Urgency of medical decision making	4.67	2.44

Technical Skill/Physical Effort (Mean)

Technical skill required	4.11	3.44
Physical effort required	2.89	2.44

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.44	2.33
Outcome depends on the skill and judgment of physician	4.44	2.89
Estimated risk of malpractice suit with poor outcome	4.22	2.00

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.67	3.00
Intra-Service intensity/complexity	4.22	3.89
Post-Service intensity/complexity	3.33	3.33

Additional Rationale and Comments

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

The specialty society panel agreed with the median pre-service time of 15 minutes, which is the same as the pre-service time for 95928 and 95929. The post-service time should be 15 minutes rather than 10 minutes, to reflect the current post-service time for 95928 and 95929. The panel reviewed the intra-service time and felt 30 minutes was more appropriate. If outliers are removed from the data, the median times are 15 pre, 30 intra, and 10 post.

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) 95928 and 95929

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 Neurology How often? Sometimes

Specialty PM&R How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 49068

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 the procedure would be provided nationally at 4 times the rate of Medicare utilization.

Specialty Neurology Frequency 37895 Percentage 77.22 %

Specialty PM&R Frequency 3935 Percentage 8.01 %

Specialty Frequency Percentage %

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

10,678 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on 90% of the 2009 Medicare utilization for CPT 95928.

Specialty Neurology Frequency 9475 Percentage 77.23 %

Specialty PM&R	Frequency 985	Percentage 8.02 %
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Specialty	Frequency	Percentage	%
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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

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. 95929

March 30, 2011

Barbara Levy, MD
Chair, RVS Update Committee (RUC)
American Medical Association
515 North State Street
Chicago, IL 60654

Dear Dr. Levy:

The American Academy of Neurology, American Academy of Physical Medicine and Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine, and the American Clinical Neurophysiology Society would like to confirm the direct practice expense inputs for 95938 (Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs).

The PE Subcommittee and RUC approved the direct inputs at the February RUC meeting, pending resolution of whether the electrodes are single use or reusable. Upon further investigation, the typical medical practice today uses disposable electrodes rather than reusable electrodes. The supplies for the service include 16 EEG electrodes (SD165) and 1 ground electrode (CD059), with no time on line 42 to clean and sterilize electrodes.

If you have any questions, please contact AAN staff Amanda Becker at abecker@aan.com or 651-695-2718.

Sincerely,

Marianna V. Spanaki, MD, PhD
AAN Advisor

Joseph P. Zuhosky, MD
AAPMR Advisor

Benn E. Smith, MD
AANEM Advisor

Marc R. Nuwer, MD, PhD
ACNS Advisor

	A	B	C	D	E
1	Revised April 21, 2011			95939	95928
2	Meeting Date: April 2011 AMA/Specialty Society RVS Update Committee Recommendation			Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
		CMS	Staff		
3	LOCATION	Code	Type	Non Facility	Non Facility
4	GLOBAL PERIOD			XXX	XXX
5	TOTAL CLINICAL LABOR TIME	L047B	REEGT	158.0	140.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			8.0	8.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			150.0	129.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			0.0	3.0
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	Review requisition. Assess for special needs.			5	5
17	Give patient instructions for test preparation (eg, hair lotion) and what to expect on the day of testing.			3	3
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			3	3
22	Obtain vital signs				
23	Provide pre-service education/obtain consent				
24	Prepare room, equipment, supplies			2	2
25	Setup scope (non facility setting only)				
26	Prepare and position patient/ monitor patient/ set up IV				
27	Have patient go to bathroom. Position patient for testing.			0	0
28	Measure and mark head and peripheral locations for electrode. Apply and secure electrodes.			12	12
29	Initiate baseline nerve conduction study				
30	Check impedances, reapply as needed.			0	4
31	Set up machine with testing parameters.			0	0
32	Sedate/apply anesthesia				
33	Intra-service				
34	Assist physician in performing procedure. Test left arm for shoulder stimulation; test left arm for spine stimulation; test left arm for scalp stimulation (2-3 repetitions per limb). Repeatedly coach patient to relax, and reposition pillow and limb as needed. Test right arm at 3 sites successively. Test left leg at 3 sites successively. Test right leg at 3 sites successively.			109	84
35	Complete worksheets.			3	3
36	Remove electrodes and clean up patient.			10	10
37	Release patient. Give discharge instructions.			3	3
38	Post-Service				
39	Monitor pt. following service/check tubes, monitors, drains				
40	Clean room/equipment by physician staff			3	3
41	Clean				
42	Complete medical record, and archive data.			5	5
43	Clean Scope				
44	Clean Surgical Instrument Package				
45	Complete diagnostic forms, lab & X-ray requisitions				
46	Review/read X-ray, lab, and pathology reports				
47	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions				
48	Discharge day management				
49	Other Clinical Activity (please specify)				
50	End: Patient leaves office				
51	POST-SERVICE Period				
52	Start: Patient leaves office/facility				
53	Conduct phone calls/call in prescriptions			0	3

	A	B	C	D	E
1	Revised April 21, 2011			95939	95928
2	Meeting Date: April 2011 AMA/Specialty Society RVS Update Committee Recommendation	CMS	Staff	Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs	Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs
3	LOCATION	Code	Type	Non Facility	Non Facility
65	MEDICAL SUPPLIES	Code	Unit		
66	measuring tape, paper	SK048	item	1	1
67	paper, recording (per sheet)	SK059	item	12	12
68	tape, porous-hypoallergenic 2in (Scanpore)	SG077	inch	48	48
69	gauze, sterile 4in x 4in (4 pack uou)	SG056	item	2	2
70	swab-pad, alcohol	SJ053	item	4	4
71	electrode skin prep gel (NuPrep)	SJ022	ml	4	20
72	collodion (2 oz uou)	SJ014	item	0	1
73	drape, non-sterile, sheet 40in x 60in	SB006	item	1	1
74	acetone	SL001	ml	0	15
75	electrode conductive gel	SJ020	ml	0	2
76	electrode, EEG (single)	SD165	item	24	16
77	needle, blunt tip	SC034	item	0	1
78	syringe, 3ml	SC055	item	0	1
79	glutaraldehyde 3.4% (Cidex, Maxicide, Wavicide)	SM018	oz	0.34	0.34
80	pack, minimum multi-specialty visit	SA048	pack	1	1
81	emery board	SK021	item	1	
82	electrode, ground	SD059	item	1	1
83	Equipment	Code	Unit		
84	air compressor, safety	EQ047		0	1
85	EMG-NCV-EP system, 8 channel	EQ024		150	1
86	table, exam	EF023		150	1
87	magnetic stimulator hand coil (70-90mm)	EQ178		150	
88	magnetic stimulator leg coil (110mm)	EQ179		150	
89	magnetic stimulator system (BiStim)	EQ180		150	

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Originated from the RUC Relativity Assessment - Harvard Valued – Utilization over 100,000 Screen.

April 2011
CT Head/Brain

In October 2009, CPT code 70470 was identified through the Relativity Assessment Workgroup’s Harvard Valued- Utilization over 100,000 Screen, and the RUC recommended that this service be surveyed.

70470 Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections

The RUC reviewed the survey results from 106 physicians for CPT code 70470 which indicated a median work RVU of 1.40 with total physician work time of 25 minutes. Although the survey median physician service time is greater than the current Harvard time, the specialty noted that there is no compelling evidence to change the current work RVU of 1.27 for this service. The RUC compared the survey results to key reference service 74160 *Computed tomography, abdomen; with contrast material(s)* (work RVU = 1.27, total time = 23 minutes) and 70596 *Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 1.75, total time = 38 minutes). The RUC agreed that the comparison codes are similar services, and although the survey results appeared to indicate that 70470 is more work than 74160, the specialty and the RUC agreed the 25th percentile survey work RVU of 1.27 represented an accurate work value for 70470 with regards to time, intensity, and complexity to perform. The RUC also agreed that the survey 25th percentile work RVU of 1.27 appropriately places this service in the proper rank order. **The RUC recommends a work RVU of 1.27 for CPT code 70470.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
70470	Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections	XXX	1.27 (No Change)

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

CPT Code: 70470	Tracking Number	Original Specialty Recommended RVU: 1.27
		Presented Recommended RVU: 1.27
Global Period: XXX		RUC Recommended RVU: 1.27

CPT Descriptor: Computed tomography, head or brain, without contrast material, followed by contrast material(s) and further sections

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: 72-year-old man with a contraindication to MRI with metastatic small cell lung cancer, presenting with new headache and hemiparesis.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 8%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review the request for appropriateness, review clinical history.
- Review lab studies to assess renal function. Review medical record for allergy history, absence of contraindications to contrast injection, factors predisposing to contrast-induced nephrotoxicity, and adjust contrast product and amount to be injected. Pre-hydrate if necessary.
- Review the nature and risks of contrast reaction to the patient and obtain informed consent where applicable. Supervise IV placement.
- Review any prior applicable studies.
- After determining necessity for both pre-contrast and post-contrast scans, communicate protocol to technologist.

Description of Intra-Service Work:

- Obtain/interpret scout views of area to be imaged.
- Obtain/review non-contrast CT images.
- Supervise low- or iso-osmolar contrast injection, supervise monitoring for contrast reaction and extravasation.
- Obtain the contrast-phase CT images and review, consider obtaining delayed-phase CT images.
- Supervise processing of two-dimensional reconstructions.

- Interpret the axial source images of the pre-contrast sequence, the post-contrast sequence, and the multiplanar reformats, in brain, subdural, stroke, vascular, and bone windows. Evaluate brain parenchyma; ventricular system; subdural and subarachnoid spaces; arterial and dural venous sinus vascular structures; meninges; calvarium; sella, cavernous sinuses, petrous temporal bones; skull base, fissures, and foramina; orbits; superficial soft tissues; paranasal sinuses. Count metastatic lesions and measure in two dimensions, if applicable. Evaluate for non-neoplastic etiologies of patient's symptoms, such as ischemia/infarction, including vascular reformats, if applicable.
- Compare to all pertinent available prior studies.
- Dictate report.

Description of Post-Service Work:

- Review and sign the final report.
- Discuss findings with referring physician/emergency department.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., William D. Donovan, M.D., M.P.H., Jacqueline A. Bello M.D.				
Specialty(s):	American College of Radiology, American Society of Neuroradiology, Association of University Radiologists				
CPT Code:	70470				
Sample Size:	250	Resp N:	106	Response: 42.4 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		20.00	100.00	325.00	700.00
Survey RVW:		0.82	1.27	1.40	3.00
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	10.00	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	99233x 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:	70470	Recommended Physician Work RVU: 1.27		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
74160	XXX	1.27	RUC Time

CPT Descriptor Computed tomography, abdomen; 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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
62270	000	1.37	RUC Time	78,068

CPT Descriptor 1 Spinal puncture, lumbar, diagnostic

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
		0.00		

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 25 % of respondents: 23.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 70470	<u>Key Reference CPT Code:</u> 74160	<u>Source of Time</u> RUC Time
Median Pre-Service Time	5.00	3.00	
Median Intra-Service Time	15.00	15.00	
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	25.00	23.00	
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	3.71	3.83
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.63	3.58
--	------	------

Urgency of medical decision making	4.04	3.67
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.88	3.75
--------------------------	------	------

Physical effort required	2.88	2.92
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.13	3.58
---	------	------

Outcome depends on the skill and judgment of physician	4.42	4.25
--	------	------

Estimated risk of malpractice suit with poor outcome	4.42	4.08
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.48	2.56
----------------------------------	------	------

Intra-Service intensity/complexity	3.72	3.64
------------------------------------	------	------

Post-Service intensity/complexity	2.52	2.46
-----------------------------------	------	------

Additional Rationale and Comments

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

Background

Code 70470 (Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections) was identified in the 5-year review screen of Harvard-valued procedures with greater than 100K utilization. Its current value is 1.27, which was affirmed in the first 5-year review. Its current time

is listed in the RUC database as 9 total minutes; this is an anomalous value of unclear origin that is incongruent with other procedures of similar work whose values are of similar vintage.

Compelling Evidence

While our societies do not plan to submit compelling evidence arguments, we would point out that there have clearly been revolutionary changes in CT technology over the past fifteen years, resulting in routine generation of many more images, with much thinner slice profile, than was possible at the time this code was previously valued. This has allowed for the creation of high-quality multiplanar reformats, now routinely generated, also not practical prior to multislice helical technology. This has meant that the interpreting radiologist has significantly more images to interpret than when this code was last examined.

Until 2006, 2D reconstructions were separately reportable as code, 76375, which was reimbursed at 0.22 RVU. Code 76375 has since been replaced by codes 76376 and 76377 which describe only 3D reconstructions. The work associated with 2D reconstructions is now bundled into existing CT codes without billable capture of the work associated with interpreting the 2D reconstructions (ie, no additional RVUs).

Another evolutionary change in professional work concerns the issue of radiation safety. With increased public, societal, and regulatory scrutiny, there is now a manifest necessity to routinely and with certainty establish that the minimum amount of ionizing radiation is being used to achieve diagnostic image quality. This has required imaging facilities to review and in many cases revise their scan protocols, and to closely assess scanning needs on an individual patient basis. This has had a measurable change in practice in many areas of CT.

However, the societies feel that these changes have had greater professional impact on other CT codes more than on this one. With other items on the compelling evidence list remaining fairly static, the societies are recommending maintenance of the current professional work value.

Time and RVW recommendation

The ACR and ASNR surveyed code 70470 and we received a total of 106 survey responses. The societies convened an expert panel that included a number of physicians familiar with the service to review the survey data.

The median times were 5 minutes pre-service time, 15 minutes intra-service time, and 5 minutes post-service time. Survey respondents reported a median RVU of 1.40, with 1.27 as the 25th percentile.

We recommend maintaining the current work RVU of 1.27, with 5 minutes pre time, 15 minutes intra time, and 5 minutes post time.

Reference Services

The key reference service chosen was 74160 (Computed tomography, abdomen; with contrast material(s)), valued by the RUC at 1.27 RVU. This MPC code has times of 3 minutes, 15 minutes, and 5 minutes. The surveyees reported that 70470, the code under review, exceeds the key reference service code in 8 of 11 intensity and complexity measures. For instance, the surveyees clearly felt that the risk of an adverse outcome, the urgency with which decisions need to be made, and the technical skill required are more substantial and of greater consequence when evaluating issues related to the brain, its coverings, and the skull base than with those of the abdomen.

The second most frequently chosen reference service was 70496 (Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing), 1.75 RVU, with 8 min pre, 20 min intra and 10 min post times. The overall work and the physician responsibility of the surveyed procedure are very similar to this reference code, in that it examines the same volume of tissue, in both pre-contrast and contrast-enhanced phases. CTA entails more detailed evaluation of the vasculature, and there is generally more post-processing involved, resulting in a modestly greater amount of physician time and work.

The third most commonly chosen reference service was 74177 (Computed tomography, abdomen and pelvis; with contrast material(s)), a new code that was recently RUC valued at 1.82 with times of 5 min pre, 25 min intra and 5 min post.

Code	Descriptor	Work RVU	Physician Time
74160	CT abd w/ contrast	1.27	3 / 15 / 5
70496	CTA of head w/&w/o contrast	1.75	8 / 20 / 10
74177	CT abd/pelvis w/ contrast	1.82	5 / 25 / 5

Additional codes supporting the current value for 70470

- 78306 (Bone and/or joint imaging; whole body) with work value of 0.86 and time of 5 min pre, 8 min intra and 5 min of post.
- 78454 (Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection) with work value of 1.34 and time of 5 min pre, 15 min of intra and 5 min of post. As with the study in question, this is a two-phase exam requiring separate evaluation of the paired components of the study, and then comparison of the two.
- 78451 (Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)) with work value of 1.38 and time of 10 min pre, 15 min intra and 10 min post. As with the current study, this requires evaluation of numerous thin-section images in multiple planes.
- 78811 (Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)) with work value of 1.54 and time of 10 min pre, 20 min intra and 10 min post.
- 70542 (Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)) with work value of 1.62 and time of 8 min pre, 15 min intra and 10 min post.

Code	Descriptor	Work RVU	Physician Time
78306	Bone imaging whole body	0.86	5 / 8 / 5
78454	MPI, planar; multiple studies	1.34	5 / 15 / 5
78451	MPI, SPECT; single study	1.38	10 / 15 / 10
78811	PET imaging; limited area	1.54	10 / 20 / 10
70542	MRI orbit/face w/ contrast	1.62	8 / 15 / 10

Rank Order Considerations

The current value for the exam in question also demonstrates appropriate rank order within the greater group of CT codes, in addition to those listed above. For example:

- 72192, CT pelvis w/o contrast: work value of 1.09 and time of 3/10/5.
- 74150, CT Abdomen w/o contrast: work value of 1.19 and time of 3/12/5.
- 71260, CT Chest w/contrast: work value of 1.24 and time of 3/15/5.
- 75572, CT Heart w/contrast, including 3D: work value of 1.75 and time of 10/20/10.

Code	Descriptor	Work RVU	Physician Time
72192	CT pelvis w/o contrast	1.09	3 / 10 / 5
74150	CT abdomen w/o contrast	1.19	3 / 12 / 5
71260	CT chest w/ contrast	1.24	3 / 15 / 5
70470	CT head/brain w/o & w/ contrast	1.27	5 / 15 / 5
75572	CT heart w/ contrast	1.75	10 / 20 / 10

Summary

The societies feel this is a strong survey on the basis of (a) the robust survey; (b) the close correlation in values with the key reference service, but with higher intensity and complexity measures; (c) the directly comparable nature of the work compared to Head CTA; (d) appropriate rank order; and (e) the somewhat-but-not-compellingly-increased amount of work to protocol and interpret these studies. Considered in aggregate, the societies believe this information provides a strong argument to maintain the current work value of 1.27 RVU, with 5 minutes pre time, 15 minutes intra time, and 5 minutes post time.

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:

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) 70470

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 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? 746139

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 70470 in a one year period is estimated to be 746,139.

Specialty Radiology Frequency 529759 Percentage 71.00 %

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?

248,713 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 Medicare data estimates that code 70470 was billed approximately 248,713.

Specialty Radiology Frequency 176586 Percentage 70.99 %

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 70470

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 Committee
Summary of Recommendations
Originated from the RUC Relativity Assessment – Low Value-High Volume Screen

April 2011

X-Ray Exam of Neck/Spine

In October 2010, the Relativity Assessment Workgroup identified CPT code 72040 *Radiologic examination, spine, cervical; 2 or 3 views* through the CMS Low Value/High Volume screen. In preparation for surveying this code, the specialty societies identified an issue with a code descriptor for a code in the immediate family of the identified service, CPT code 72052 *Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies*. The RUC agreed with the specialties that the descriptor for 72052 should be revised to specify the number of inherent views so that survey respondents are not confused during the survey process. **The RUC requests that CPT code 72040 will be referred to the October 2011 CPT Editorial Panel meeting with an intended RUC survey for this family at the January 2012 RUC meeting.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
72040	Radiologic examination, spine, cervical; 2 or 3 views	XXX	RUC Request Referral to CPT Editorial Panel



April 5, 2011

Barbara Levy, M.D.
Chair, AMA/ Relative Value Update (RUC) Committee
American Medical Association
515 N. State St.
Chicago, IL 60610

Re: CPT code 72040

Dear Dr. Levy,

CPT Code 72040, *Radiologic examination, spine, cervical; 2 or 3 views*, was identified by CMS in the Low Value/High Volume screen and has a RUC time source of CMS/Other. As a result, CMS requested the code be resurveyed and reviewed by the RUC in April 2011.

The American College of Radiology (ACR), the American Academy of Orthopaedic Surgeons (AAOS) and the North American Spine Society (NASS) recommend that this code be sent to the CPT panel for revision of the code descriptor for another code in the family 72052 (*Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies*) to clarify the number of views 72052 entails. We anticipate this editorial change will be presented at the October CPT panel meeting. We will pursue the plan to survey code 72040 once we get the CPT code descriptor for 72052 revised.

Thank you for your attention to this matter.

Sincerely,

Geraldine McGinty, M.D.
ACR RUC Advisor

William Creevy, M.D.
AAOS RUC Advisor

William Sullivan, M.D.
NASS RUC Advisor

Cc: Sherry Smith
Zach Hochstetler
Zeke Silva, M.D.
Dan Picus, M.D.
Angela Kim
Diane Hayek
Helen Olkaba

AMA/Specialty Society RVS Update Committee
 Summary of Recommendations
Originated from the RUC Relativity Assessment – Low Value-High Volume Screen

April 2011

X-Ray Exam of Pelvis

In October 2010, the Relativity Assessment Workgroup identified CPT code 72170 through the CMS Low Value/High Volume screen. The specialty societies conducted a RUC survey for presentation at the April 2011 RUC meeting.

72170 Radiologic examination, pelvis; 1 or 2 views

The RUC reviewed the survey results from 46 physicians for CPT code 72170. The RUC recommends pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 2 minutes. The RUC reviewed the survey work values and agreed with the specialties that there is no compelling evidence to change the current work value for this service. To justify the current work RVU of 0.17 for 72170, the RUC reviewed the key reference service 73510 *Radiologic examination, hip, unilateral; complete, minimum of 2 views* (work RVU= 0.21) and agreed that the reference code should be valued higher due to greater intra-service time, 5 minutes compared to 4 minutes, and greater number of views. In addition, the RUC reviewed 72170 in comparison to the analogous code 72190 *Radiologic examination, pelvis; complete, minimum of 3 views* (work RVU= 0.21) and agreed that the reference code should be valued higher due to a greater number of views, 3 compared to 1 or 2. **The RUC recommends a work RVU of 0.17 for CPT code 72170.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
72170	Radiologic examination, pelvis; 1 or 2 views	XXX	0.17 (No Change)

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

CPT Code: 72170 Tracking Number Original Specialty Recommended RVU: **0.17**
Presented Recommended RVU: **0.17**
Global Period: XXX RUC Recommended RVU: **0.17**

CPT Descriptor: Radiologic examination, pelvis; 1 or 2 views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 73-year-old woman slips and falls and has pain over her superior pubic ramus. A radiologic exam is performed to evaluate for fracture of the pelvis.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history.
- Review any prior applicable plain film or imaging studies.

Description of Intra-Service Work:

- Supervise technologist performing the examination.
- Interpret the radiographs of the pelvis and compare the exam findings 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)		04/2011			
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., John Heiner, M.D., and Peter Mangone, M.D.				
Specialty(s):	American College of Radiology and American Academy of Orthopaedic Surgeons				
CPT Code:	72170				
Sample Size:	678	Resp N:	46	Response: 6.7 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		10.00	50.00	100.00	250.00
Survey RVW:		0.17	0.20	0.21	2.00
Pre-Service Evaluation Time:				2.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		0.00	3.00	4.00	30.00
Immediate Post Service-Time:		<u>2.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:	72170	Recommended Physician Work RVU: 0.17		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		1.00	0.00	1.00
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:		4.00		
Immediate Post Service-Time:		<u>2.00</u>		
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73510	XXX	0.21	RUC Time

CPT Descriptor Radiologic examination, hip, unilateral; complete, minimum of 2 views**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
73560	XXX	0.17	RUC Time	2,137,514

CPT Descriptor 1 Radiologic examination, knee; 1 or 2 views

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 45.6 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 72170	<u>Key Reference CPT Code:</u> 73510	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	4.00	5.00	
Median Immediate Post-service Time	2.00	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	7.00	5.00	
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	2.90
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.81	2.81
Urgency of medical decision making	3.19	3.14

Technical Skill/Physical Effort (Mean)

Technical skill required	2.43	2.48
Physical effort required	1.71	1.81

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.10	3.00
Outcome depends on the skill and judgment of physician	3.10	3.14
Estimated risk of malpractice suit with poor outcome	3.48	3.43

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.05	2.10
Intra-Service intensity/complexity	2.81	2.86
Post-Service intensity/complexity	2.24	2.33

Additional Rationale and Comments

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

Background

Four plain film radiograph codes were identified by CMS in the Low Value/High Volume screen and each have a RUC time source of CMS/Other. As a result, the RAW requested the codes be surveyed and reviewed by the RUC in April 2011. The specialty societies recommended that code 72040 (*Radiologic examination,*

spine, cervical; 2 or 3 views) be referred to the CPT panel for revision of the code descriptor for another code in the family 72052 (*Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies*) to clarify the number of views 72052 entails.

The specialty societies surveyed the other three codes with the ACR and AAOS participating in all three surveys (72170: Radiologic examination, pelvis; 1 or 2 views, 73030: Radiologic examination, shoulder; complete, minimum of 2 views, and 73620: Radiologic examination, foot; 2 views) with the APMA only participating in the foot survey. The societies convened an expert panel that included a number of physicians familiar with the services to review the survey data.

Work RVU recommendation

For all three codes, we are recommending that the current value be maintained: foot-0.16 RVU, pelvis-0.17 RVU; shoulder-.18 RVU. This is lower than the median RVU recommendation for all three codes since the societies did not believe that compelling evidence standards for an increase in value had been met.

Pre and Post Service Times

For all three codes, the societies recommend the same pre and post times of 1 and 2 minutes, respectively. These pre and post service times are supported by the median survey results of the shoulder and hip. For the foot, we are recommending subtracting 4 minutes from the median pre time and 3 minutes from the median post times to reach our recommended times. For the pelvis and shoulder, we recommend subtracting 1 minute from the pre-service median survey results. This recommendation of 1 minute pre and 2 minutes post is also congruent with the times accepted by the RUC for a family of plain film codes of the lumbar spine presented in February of 2011 (72100, 72110, 72114 and 72120).

Intra Service Times

We are recommending the same intra-service time for all three codes: 4 minutes. This is the median survey time for the pelvis and shoulder and between the 25th and median times for the foot. All three studies involve two views of the anatomic structure and our panel does not feel the intra-service work is significantly different between the three studies.

Summary of recommendations for the pelvis

The specialty societies are recommending the current RVU of 0.17 with pre, intra and post times of 1, 4, and 2 minutes respectively. This recommendation is supported by the most commonly chosen key reference service, 73510 (Radiologic examination, hip, unilateral; complete, minimum of 2 views) with 0.21 RVU and 5 minutes of total time. Code 73510 was RUC reviewed in October 2009 with its time validated based on a crosswalk methodology. Our recommendation is also supported by MPC code 73560 (Radiologic examination, knee; 1 or 2 views) with 0.17 RVU and 3 minutes of intra time. Our recommendation also compares favorably with two of the recently surveyed lumbar spine plain films. 72100 and 72120 both involve two views of the anatomic region and are both valued at 0.22 RVU and 6 minutes of total time.

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:

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) 72170

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 Orthopedic surgery How often? Commonly

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 5049135

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 72170 in one year period is estimated to be 5049135.

Specialty Orthopedic Surgery Frequency 3716668 Percentage 73.60 %

Specialty Diagnostic Radiology Frequency 512992 Percentage 10.15 %

Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,683,045 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 Medicare data estimates that code 72170 was billed approximately 1683045.

Specialty Orthopedic Surgery Frequency 1239057 Percentage 73.61 %

Specialty Diagnostic Radiology Frequency 171165 Percentage 10.16 %

Specialty	Frequency	Percentage	%
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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 72170

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 Committee
 Summary of Recommendations
Originated from the RUC Relativity Assessment – Low Value-High Volume Screen

April 2011

X-Ray Exam of Shoulder

In October 2010, the Relativity Assessment Workgroup identified CPT code 73030 through the CMS Low Value/High Volume screen. The specialty societies conducted a RUC survey for presentation at the April 2011 RUC meeting.

73030 Radiologic examination, shoulder; complete, minimum of 2 views

The RUC reviewed the survey results from 47 physicians for CPT code 73030. The RUC recommends pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 2 minutes. The RUC agreed with the specialties that there is no compelling evidence to change the current work value for this service. To justify the current work value of 0.18 for code 73030, the RUC reviewed MPC code 73560 *Radiologic examination, knee; 1 or 2 views* (work RVU= 0.17) and agreed that the surveyed code should be valued slightly higher due to greater intra-service time of 4 minutes compared to 3 minutes. In addition, the RUC compared CPT code 73030 to CPT code 72170 *Radiologic examination, pelvis; 1 or 2 views* (RUC recommended work RVU= 0.17) and agreed that while the two services have the same recommended physician service time, 73030 should be valued slightly higher because the shoulder is typically viewed with internal and external rotations to get difference visualizations of the joint, while the pelvis is a stable joint. Furthermore, 72170 requires 1 to 2 views, while 73030 requires a minimum of 2 views. **The RUC recommends a work RVU of 0.18 for CPT code 73030.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
73030	Radiologic examination, shoulder; complete, minimum of 2 views	XXX	0.18 (No Change)

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

CPT Code: 73030 Tracking Number Original Specialty Recommended RVU: **0.18**
 Presented Recommended RVU: **0.18**
 Global Period: XXX RUC Recommended RVU: **0.18**

CPT Descriptor: Radiologic examination, shoulder; complete, minimum of 2 views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 70-year-old male has severe pain with overhead activities and cannot raise his left arm at the shoulder. A radiologic exam is performed to evaluate for arthritis of the shoulder.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history.
- Review any prior applicable plain film or imaging studies.

Description of Intra-Service Work:

- Supervise technologist performing the examination.
- Interpret the radiographs of the shoulder and compare the exam findings 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)		04/2011			
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., John Heiner, M.D., and Peter Mangone, M.D.				
Specialty(s):	American College of Radiology and American Academy of Orthopaedic Surgeons				
CPT Code:	73030				
Sample Size:	678	Resp N:	47	Response: 6.9 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		2.00	100.00	200.00	350.00
Survey RVW:		0.16	0.18	0.20	2.00
Pre-Service Evaluation Time:				2.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		0.00	2.00	4.00	30.00
Immediate Post Service-Time:	<u>2.00</u>				
Post Operative Visits	Total Min**	CPT Code and Number of Visits			
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00		
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00	
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00	14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00	57x 0.00
Sub Obs Care:	<u>0.00</u>	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:	73030	Recommended Physician Work RVU: 0.18		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		1.00	0.00	1.00
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:		4.00		
Immediate Post Service-Time:	<u>2.00</u>			
Post Operative Visits	Total Min**	CPT Code and Number of Visits		
Critical Care time/visit(s):	<u>0.00</u>	99291x 0.00	99292x 0.00	
Other Hospital time/visit(s):	<u>0.00</u>	99231x 0.00	99232x 0.00	99233x 0.00
Discharge Day Mgmt:	<u>0.00</u>	99238x 0.0	99239x 0.0	99217x 0.00
Office time/visit(s):	<u>0.00</u>	99211x 0.00	12x 0.00	13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	<u>0.00</u>	99354x 0.00	55x 0.00	56x 0.00 57x 0.00
Sub Obs Care:	<u>0.00</u>	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73510	XXX	0.21	RUC Time

CPT Descriptor Radiologic examination, hip, unilateral; complete, minimum of 2 views**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
73560	XXX	0.17	RUC Time	2,137,514

CPT Descriptor 1 Radiologic examination, knee; 1 or 2 views

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 34.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 73030	<u>Key Reference CPT Code:</u> 73510	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	0.00	
Median Intra-Service Time	4.00	5.00	
Median Immediate Post-service Time	2.00	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	7.00	5.00	
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	3.20	3.14
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.00	3.00
--	------	------

Urgency of medical decision making	2.67	2.71
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.47	2.36
--------------------------	------	------

Physical effort required	1.80	1.79
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.60	2.36
---	------	------

Outcome depends on the skill and judgment of physician	2.80	2.64
--	------	------

Estimated risk of malpractice suit with poor outcome	2.60	2.71
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.56	2.27
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Intra-Service intensity/complexity	3.13	3.07
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Post-Service intensity/complexity	2.69	2.67
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Additional Rationale and Comments

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

Background

Four plain film radiograph codes were identified by CMS in the Low Value/High Volume screen and each have a RUC time source of CMS/Other. As a result, the RAW requested the codes be surveyed and reviewed by the RUC in April 2011. The specialty societies recommended that code 72040 (*Radiologic examination,*

spine, cervical; 2 or 3 views) be referred to the CPT panel for revision of the code descriptor for another code in the family 72052 (*Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies*) to clarify the number of views 72052 entails.

The specialty societies surveyed the other three codes with the ACR and AAOS participating in all three surveys (72170: Radiologic examination, pelvis; 1 or 2 views, 73030: Radiologic examination, shoulder; complete, minimum of 2 views, and 73620: Radiologic examination, foot; 2 views) with the APMA only participating in the foot survey. The societies convened an expert panel that included a number of physicians familiar with the services to review the survey data.

Work RVU recommendation

For all three codes, we are recommending that the current value be maintained: foot-0.16 RVU, pelvis-0.17 RVU; shoulder-.18 RVU. This is lower than the median RVU recommendation for all three codes since the societies did not believe that compelling evidence standards for an increase in value had been met.

Pre and Post Service Times

For all three codes, the societies recommend the same pre and post times of 1 and 2 minutes, respectively. These pre and post service times are supported by the median survey results of the shoulder and hip. For the foot, we are recommending subtracting 4 minutes from the median pre time and 3 minutes from the median post times to reach our recommended times. For the pelvis and shoulder, we recommend subtracting 1 minute from the pre-service median survey results. This recommendation of 1 minute pre and 2 minutes post is also congruent with the times accepted by the RUC for a family of plain film codes of the lumbar spine presented in February of 2011 (72100, 72110, 72114 and 72120).

Intra Service Times

We are recommending the same intra-service time for all three codes: 4 minutes. This is the median survey time for the pelvis and shoulder and between the 25th and median times for the foot. All three studies involve two views of the anatomic structure and our panel does not feel the intra-service work is significantly different between the three studies.

Summary of recommendations for the shoulder

The specialty societies are recommending the current RVU of 0.18 with pre, intra and post times of 1, 4, and 2 minutes respectively. This recommendation is supported by the most commonly chosen key reference service, 73510 (Radiologic examination, hip, unilateral; complete, minimum of 2 views) with 0.21 RVU and 5 minutes of total time. Code 73510 was RUC reviewed in October 2009 with its time validated based on a crosswalk methodology. Our recommendation is also supported by our MPC code 73560 (Radiologic examination, knee; 1 or 2 views) with 0.17 RVU and 3 minutes of intra time. Our recommendation also compares favorably with two of the recently surveyed lumbar spine plain films. 72100 and 72120 both involve two views of the anatomic region and are both valued at 0.22 RVU and 6 minutes of total time.

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:

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.

AMA/Specialty Society RVS Update Committee
 Summary of Recommendations
Originated from the RUC Relativity Assessment – Low Value-High Volume Screen

April 2011

X-Ray Exam of Foot

In October 2010, the Relativity Assessment Workgroup identified CPT code 73620 through the CMS Low Value/High Volume screen. The specialty societies conducted a RUC survey for presentation at the April 2011 RUC meeting.

73620 Radiologic examination, foot; 2 views

The RUC reviewed the survey results from 118 physicians for CPT code 73620. The RUC recommends pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute. The RUC reduced the median survey intra-service and post-service time by one minute each to align the intra-service time with previous RUC reviewed x-ray services and to ensure there is no duplication of work with an Evaluation and Management service typically billed on the same day. The RUC reviewed the survey work values and agreed with the specialties that there is no compelling evidence to change the current work value for this service. To justify the current work value of 0.16 for code 73620, the RUC compared 73620 to analogous code 73630 *Radiologic examination, foot; complete, minimum of 3 views* (work RVU= 0.17) and agreed that while the services have the same physician time, the reference code should be valued slightly higher due to a greater number of required views, 3 views compared to 2 views. To ensure the work value is relative across other x-ray services, the RUC compared these two services to analogous x-ray codes in the hand: 73120 *Radiologic examination, hand; 2 views* (work RVU= 0.16) and 73130 *Radiologic examination, hand; minimum of 3 views* (work RVU= 0.17). These similar services have the same physician time components as the x-ray foot codes and are valued the same, with the 3 view x-ray, 73130, valued at a work RVU of 0.17 and the 2 view x-ray, 73120, valued at a work RVU of 0.16. **The RUC recommends a work RVU of 0.16 for CPT code 73620.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
73620	Radiologic examination, foot; 2 views	XXX	0.16 (No Change)

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

CPT Code: 73620 Tracking Number Original Specialty Recommended RVU: **0.16**
 Presented Recommended RVU: **0.16**
 Global Period: XXX RUC Recommended RVU: **0.16**

CPT Descriptor: Radiologic examination, foot; 2 views

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old woman drops a weight on her foot and has severe pain. A radiologic exam is performed to evaluate for fracture of the foot.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review the reason for the exam and any pertinent clinical history.
- Review any prior applicable plain film or imaging studies.

Description of Intra-Service Work:

- Supervise technologist performing the examination.
- Interpret the radiographs of the foot and compare the exam findings to previous studies.
- Dictate report for the medical record.

Description of Post-Service Work:

- Review and sign final report.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	John Heiner, M.D., Geraldine McGinty, M.D., Zeke Silva, M.D., Peter Mangone, M. D., Seth Rubenstein, DPM and Timothy Tillo, DPM				
Specialty(s):	American Academy of Orthopaedic Surgeons, American College of Radiology, American Podiatric Medical Association				
CPT Code:	73620				
Sample Size:	1923	Resp N:	118	Response: 6.1 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		4.00	50.00	118.00	300.00
Survey RVW:		0.13	0.16	0.18	0.21
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	3.00	5.00	10.00
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	99233x 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:	73620	Recommended Physician Work RVU: 0.16		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		1.00	0.00	1.00
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:		3.00		
Immediate Post Service-Time:		1.00		
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
73120	XXX	0.16	RUC Time

CPT Descriptor Radiologic examination, hand; 2 views**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
73560	XXX	0.17	RUC Time	2,137,514

CPT Descriptor 1 Radiologic examination, knee; 1 or 2 views

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
71020	XXX	0.22	RUC Time	13,740,080

CPT Descriptor 2 Radiologic examination, chest, 2 views, frontal and lateral;

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 40 % of respondents: 33.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 73620	<u>Key Reference CPT Code:</u> 73120	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	1.00	
Median Intra-Service Time	3.00	3.00	
Median Immediate Post-service Time	1.00	1.00	
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	5.00	5.00	
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	2.80	2.77
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.48	2.44
Urgency of medical decision making	2.90	2.82

Technical Skill/Physical Effort (Mean)

Technical skill required	2.65	2.54
Physical effort required	1.83	1.87

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.56	2.55
Outcome depends on the skill and judgment of physician	3.10	3.11
Estimated risk of malpractice suit with poor outcome	3.13	3.16

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.18	2.13
Intra-Service intensity/complexity	2.63	2.54
Post-Service intensity/complexity	2.35	2.42

Additional Rationale and Comments

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

Background

Four plain film radiograph codes were identified by CMS in the Low Value/High Volume screen and each have a RUC time source of CMS/Other. As a result, the RAW requested the codes be surveyed and reviewed by the RUC in April 2011. The specialty societies recommended that code 72040 (*Radiologic examination, spine, cervical; 2 or 3 views*) be referred to the CPT panel for revision of the code descriptor for another code

in the family 72052 (*Radiologic examination, spine, cervical; complete, including oblique and flexion and/or extension studies*) to clarify the number of views 72052 entails.

The specialty societies surveyed the other three codes with the ACR and AAOS participating in all three surveys (72170: Radiologic examination, pelvis; 1 or 2 views, 73030: Radiologic examination, shoulder; complete, minimum of 2 views, and 73620: Radiologic examination, foot; 2 views) with the APMA only participating in the foot survey. The societies convened an expert panel that included a number of physicians familiar with the services to review the survey data.

Work RVU recommendation

For all three codes, we are recommending that the current value be maintained: foot-0.16 RVU, pelvis-0.17 RVU; shoulder-.18 RVU. This is lower than the median RVU recommendation for all three codes since the societies did not believe that compelling evidence standards for an increase in value had been met.

Pre and Post Service Times

For all three codes, the societies recommend the same pre and post times of 1 and 2 minutes, respectively. These pre and post service times are supported by the median survey results of the shoulder and hip. For the foot, we are recommending subtracting 4 minutes from the median pre time and 3 minutes from the median post times to reach our recommended times. For the pelvis and shoulder, we recommend subtracting 1 minute from the pre-service median survey results. This recommendation of 1 minute pre and 2 minutes post is also congruent with the times accepted by the RUC for a family of plain film codes of the lumbar spine presented in February of 2011 (72100, 72110, 72114 and 72120).

Intra Service Times

We are recommending the same intra-service time for all three codes: 4 minutes. This is the median survey time for the pelvis and shoulder and between the 25th and median times for the foot. All three studies involve two views of the anatomic structure and our panel does not feel the intra-service work is significantly different between the three studies.

Summary of recommendations for the foot

The specialty societies are recommending the current RVU of 0.16 with pre, intra and post times of 1, 4, and 2 minutes respectively. This recommendation is supported by the most commonly chosen key reference service, 73120 (Radiologic examination, hand; 2 views) with 0.16 RVU and times of 1/3/1. It is also supported by MPC code 73560 (Radiologic examination, knee; 1 or 2 views) with 0.17 RVU and 3 minutes of intra time. Our recommendation also compares favorably with two of the recently surveyed lumbar spine plain films. 72100 and 72120 both involve two views of the anatomic region and are both valued at 0.22 RVU with 6 minutes of total time.

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:

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) 73620

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 Orthopedic Surgery	How often? Sometimes
Specialty Diagnostic Radiology	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2597538
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 73620 in one year period is estimated to be 2,597,538.

Specialty Podiatry	Frequency 2022183	Percentage 77.84 %
Specialty Orthopedic Surgery	Frequency 253519	Percentage 9.75 %
Specialty Diagnostic Radiology	Frequency 51950	Percentage 1.99 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 865,846
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 data estimates that code 73620 was billed approximately 865,846.

Specialty Podiatry	Frequency 674061	Percentage 77.84 %
Specialty Orthopedic Surgery	Frequency 84506	Percentage 9.75 %
Specialty Radiology	Frequency 17316	Percentage 1.99 %

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 73620

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 Committee Summary of Recommendations
Identified as part of the MPC List Screen

April 2011

Evaluation of Wheezing

In July 2010, CMS identified code 94060 *Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration* as part of the MPC List screen. In February 2011, the RUC recommended that this service be surveyed.

The RUC reviewed the survey results from 48 pulmonary physicians and determined that the current work RVU of 0.31 be maintained as it appropriately accounts for the work required to perform this service. This value is further supported by the survey 25th percentile work RVU of 0.31. The RUC compared 94060 to key reference service 94375 *Respiratory flow volume loop* (work RVU = 0.31) and determined that the surveyed time and that of the key reference service were the same, requiring similar intensity and complexity to perform. However, 94060 is typically billed with an Evaluation and Management service. Therefore, the RUC recommends reducing the pre-service time to 3 minutes, maintaining the survey respondents intra-service time of 7.5 minutes and reducing the immediate post-service time to 3 minutes. For further support the RUC referenced similar service 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)* (work RVU = 0.30), which has similar intra-service time of 7 minutes and analogous intensity. **The RUC recommends a work RVU of 0.31 for CPT code 94060.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
94060	Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration (Do not report 94060 in conjunction with 94728, 94150, 94200, 94375)	XXX	0.31 (No Change)

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

CPT Code: 94060 Tracking Number Original Specialty Recommended RVU: **0.31**
Presented Recommended RVU: **0.31**
Global Period: XXX RUC Recommended RVU: **0.31**

CPT Descriptor: Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration (Report bronchodilator supply separately with 99070 or appropriate supply code) (For prolonged exercise test for bronchospasm with pre- and post-spirometry, use 94620)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old with a history of chronic obstructive bronchitis and emphysema is seen on a subsequent outpatient visit for increasing shortness of breath.

Percentage of Survey Respondents who found Vignette to be Typical: 79.17%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review results of previous Pulmonary Function Testing
- Review order request and diagnosis to ensure that ordered tests were performed
- Review accuracy of race, gender, age, height and smoking status

Description of Intra-Service Work:

- Verify that predicted values are correct for the patient tested
- Review spirometry curves for effort and consistency and errors in the 3-8 maneuvers both pre and post bronchodilator
- Interpret the test results.
- Record interpretation and findings in the patient record.

Description of Post-Service Work:

- Review transcribed report, checking for errors and sign the corrected report. .

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Burt Lesnick MD, FCCP, ACCP; Kathrin Nicolacakis, MD, FCCP, ATS				
Specialty(s):	American College of Chest Physicians and the American Thoracic Society				
CPT Code:	94060				
Sample Size:	153	Resp N:	48	Response: 31.3 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	50.00	125.00	500.00
Survey RVW:		0.15	0.31	0.40	0.62
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	4.75	7.50	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 0.00	99239x 0.00	99217x 0.00	
Office time/visit(s):	0.00	99211x 0.00	12x 0.00	13x 0.00	14x 0.00
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:	94060	Recommended Physician Work RVU: 0.31		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		7.50		
Immediate Post Service-Time:		3.00		
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
Prolonged Services:	0.00	99354x 0.00	55x 0.00	56x 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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
94375	XXX	0.31	RUC Time

CPT Descriptor Respiratory flow volume loop**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94010	XXX	0.17	RUC Time	1,256,953
<u>CPT Descriptor 1</u> Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94621	XXX	1.42	RUC Time	9,849

CPT Descriptor 2 Pulmonary stress testing; complex (including measurements of CO2 production, O2 uptake, and electrocardiographic recordings)

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
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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: 14 % of respondents: 29.1 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 94060	<u>Key Reference CPT Code:</u> 94375	<u>Source of Time</u> RUC Time
Median Pre-Service Time	3.00	5.00	
Median Intra-Service Time	7.50	7.00	
Median Immediate Post-service Time	3.00	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	13.50	17.00	

Other time if appropriate		
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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	2.93	2.71
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.07	2.79
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Urgency of medical decision making	2.93	2.79
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Technical Skill/Physical Effort (Mean)

Technical skill required	2.86	2.79
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Physical effort required	2.00	2.07
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.21	2.00
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Outcome depends on the skill and judgment of physician	3.00	2.86
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Estimated risk of malpractice suit with poor outcome	2.38	2.36
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INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.50	2.36
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Intra-Service intensity/complexity	2.50	2.36
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Post-Service intensity/complexity	3.21	3.07
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Additional Rationale and Comments

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

The Practice Management Committee of the American College of Chest Physicians (ACCP) and the Clinical Practice Committee of the American Thoracic Society (ATS) independently reviewed the survey data and the practice expense inputs and are submitting their consensus recommendation for RUC review.

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) typically reported with an Evaluation and Management service.

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) 94060

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 Pulmonary Disease 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? 3693216

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Extrapolated Medicare frequency by assuming that Medicare Frequency is 33.33% of the size of national frequency. Also, our assumption is using the same ratios as the Medicare data.

Specialty Pulmonary Disease Frequency 1936353 Percentage 52.42 %

Specialty Internal Medicine Frequency 794781 Percentage 21.52 %

Specialty Family Practice Frequency 330174 Percentage 8.94 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,231,072 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2009 Medicare Frequency from RUC Database

Specialty Pulmonary Disease Frequency 645451 Percentage 52.42 %

Specialty Internal Medicine Frequency 264927 Percentage 21.52 %

Specialty Family Practice Frequency 110058 Percentage 8.94 %

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 94060

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. N/A

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Identified as part of the Low Value-High Volume Screen

April 2011

Extremity Study

In October 2010, the RUC identified CPT code 93971 *Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study* as part of the Low Value-High Volume screen and requested that it be surveyed.

The RUC reviewed the survey results from 67 radiologists and vascular surgeons and recommends that the current work RVU of 0.45 be maintained as it appropriately accounts for the work required to perform this service. The RUC compared 93971 to key reference code 93923 *Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels* (work RVU = 0.45) and determined these services required the same intra-service time of 10 minutes and similar intensity and complexity to perform. The RUC noted that the current value is supported by the survey median work RVU of 0.47. **The RUC recommends a work RVU of 0.45 for CPT code 93971.**

CPT Code (●New)	CPT Descriptor	Global Period	Work RVU Recommendation
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	XXX	0.45 (No Change)

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

CPT Code: 93971 Tracking Number Original Specialty Recommended RVU: **0.45**
Presented Recommended RVU: **0.45**
Global Period: XXX RUC Recommended RVU: **0.45**

CPT Descriptor: Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 67-year-old woman who is post-operative day six after a total left knee arthroplasty complains of sudden increase in the pain and swelling of her left calf. A unilateral venous duplex ultrasound 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 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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 1%

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? 1%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review of the noninvasive diagnostic test requisition form, noting the patient's medical history, risk factors and clinical history providing the indication for the examination.
- Review of previous diagnostic studies for the patient that may be used for comparative surveillance or to diagnose disease progression.

Description of Intra-Service Work:

- Supervise technologist to identify the venous structures of the extremity. In the lower extremity, this will include the common femoral, superficial femoral, popliteal, greater saphenous, lesser saphenous and proximal tibial veins.
- Document presence and direction of flow within these veins as well as appropriate compressibility, respiratory variation and response to augmentation.
- Evaluate for superficial venous reflux. If reflux is present, evaluate the competency of the valves at the sapheno-femoral and sapheno-popliteal junctions and measure the diameter of the affected veins.
- Evaluate and characterize surrounding anatomic structures to assess for possible adjacent lymphadenopathy, soft tissue edema or soft tissue collections such as hematoma or abscess, or synovial cysts such as popliteal (Baker's) cysts.
- Interpretation is rendered indicating the severity and chronicity of the venous occlusive disease and/or venous insufficiency in the involved venous segments. Comparison to previous studies is included when prior results are available. An etiology of the patient's venous disease may be identified.

- A report is dictated.

Description of Post-Service Work:

- The report is reviewed and signed.
- Directing copies to the referring physician and/or primary care provider, completing an encounter form for billing purposes and sending the study to an archive.
- Discuss significant findings such as progression or improvement of venous disease.
- A verbal report may be directed to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):	Geraldine McGinty, M.D., Zeke Silva, M.D., Gary Seabrook, M.D., Robert Zwolak, M.D., David Han, M.D., Michael Sutherland, M.D., Mathew Sideman, M.D.					
Specialty(s):	American College of Radiology and Society for Vascular Surgery					
CPT Code:	93971					
Sample Size:	486	Resp N:	67	Response: 13.7 %		
Sample Type:	Random	Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		2.00	88.00	200.00	400.00	2500.00
Survey RVW:		0.21	0.33	0.47	0.75	1.50
Pre-Service Evaluation Time:				3.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		0.00	5.00	10.00	15.00	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:	93971	Recommended Physician Work RVU: 0.45				
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		10.00				
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93923	XXX	0.45	RUC Time

CPT Descriptor Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more level(s), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
97110	XXX	0.45	RUC Time	40,440,714
Most Recent				
<u>CPT Descriptor 1</u> Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Medicare Utilization</u>
92250	XXX	0.44	RUC Time	2,175,839
Most Recent				

CPT Descriptor 2 Fundus photography with interpretation and report

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 18 % of respondents: 26.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 93971	<u>Key Reference CPT Code:</u> 93923	<u>Source of Time</u> RUC Time
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	10.00	10.00	
Median Immediate Post-service Time	5.00	3.00	
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	18.00	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	2.56	2.78
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.78	2.89
Urgency of medical decision making	3.94	3.17

Technical Skill/Physical Effort (Mean)

Technical skill required	2.83	2.67
Physical effort required	2.33	2.17

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.67	2.39
Outcome depends on the skill and judgment of physician	3.28	3.28
Estimated risk of malpractice suit with poor outcome	3.83	3.33

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	1.94	2.00
Intra-Service intensity/complexity	3.00	2.94
Post-Service intensity/complexity	2.44	2.44

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 93971 was among 24 codes identified by CMS and for which review by the RUC was requested based on low RVUs and high utilization. At the February 2011 RUC meeting, survey was requested by the RAW since the code had CMS/Other inputs.

Compelling Evidence

While our societies do not plan to submit compelling evidence arguments, we would point out that accrediting bodies have written practice guidelines for this procedure recommending study components that were not performed when this very old CPT code was created. Examples of this additional work include colorflow ultrasound and calf vein assessment. Colorflow did not have wide commercial availability, and ultrasound technology had insufficient sensitivity to evaluate calf veins when 93971 was initially created.

Time and RVW recommendation

ACR and SVS surveyed code 93971 and we received a total of 67 survey responses. The societies convened an expert consensus panel to review the aggregated survey data and determine a recommended work RVU and recommended times.

Our survey median work RVU was 0.47 with a total time of 18 minutes. The median times were 3 minute pre-time for day of evaluation, 10 minutes intra-time, and 5 minutes immediate post-time. We recommend maintaining the current work RVU of 0.45 for 93971 which is between our survey 25% and the median survey work RVU because the value is justified not only by the survey but also by work comparison to other diagnostic and E&M services. The most commonly chosen reference code was CPT code 93923 (Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries). Code 93923 has a work RVU of 0.45 and 16 minutes total time (3 minute pre-service evaluation time, 10 minutes intra-time and 3 minutes immediate post-service time). 93923 was surveyed by the RUC in 2010 and has an IWPUT of 0.0316.

Rank Order with other ultrasound codes

The recommended work RVU of 0.45 places 93971 in an appropriate rank order with another recently RUC valued ultrasound code 76536 (Ultrasound of the soft tissues of the head and neck) which has work RVU of 0.56 and 18 minutes of total time (4 minute pre-service evaluation time, 10 minutes intra-time and 4 minutes immediate post-service time). While 93971 requires ultrasound assessment of a much larger portion of the body, the overall number, complexity and diversity of images is similar.

Comparison to E&M Services

The expert consensus panel of our two societies also points out that the physician work and physician time required for interpretation of B-mode ultrasound images, color-flow images and Doppler spectra in 93971 are very similar to the work and time involved in E&M code 99212, a low level office visit which requires at least 2 of 3 key components: a problem focused history; a problem focused examination; and/or straightforward medical decision making. 99212 has a work RVU of 0.48 and a physician time of 16 minutes.

Conclusion

A robust multispecialty survey of physician work has been performed for 93971 with a resultant median survey work RVU of 0.47. While our specialties do not plan to submit compelling evidence arguments, current clinical guidelines recommend analysis of more information than was typically collected when this code was new. The recommended work RVU is the current value of 0.45 which compares appropriately with the key arterial physiologic vascular ultrasound reference (93923), as well as a recently-surveyed nonvascular ultrasound service (76536), and a low level E&M service 99212. Considered in the aggregate, we believe this information provides a strong argument to maintain the current work RVU of 0.45.

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:

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) 93971

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 Vascular Surgery How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 4258731

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 93971 in a one year period is estimated to be 4,258,731.

Specialty Diagnostic Radiology Frequency 1277619 Percentage 29.99 %

Specialty Vascular Surgery Frequency 851746 Percentage 19.99 %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,419,577 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The 2009 Medicare data estimates that code 93971 was billed approximately 1,419,577.

Specialty Diagnostic Radiology Frequency 425873 Percentage 29.99 %

Specialty Vascular Surgery Frequency 283915 Percentage 19.99 %

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 93971

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 Committee Summary of Recommendations
Identified as part of the Low Value-Billed in Multiple Units Screen

April 2011

Percutaneous & Intracutaneous Allergy Tests

In July 2010, CMS identified code 95010, 95015 and 95024 as part of the Low Value-Billed in Multiple Units screen. In February, 2011, the RUC requested that the specialty societies resurvey codes 95010 and 95015 as the physician time for these codes were not representative of the number of units typically performed and to review the practice expense inputs only for code 95024 as the assumed typical number of tests were 12 at the time of valuation, and are now 16. The RUC agreed that a review of physician work for code 95024 was not necessary because, an RVU of 0.17 would similarly be established for the battery of tests still resulting in a work RVU of 0.01 (0.17 divided by 16). Additionally, the RUC appropriately divided the physician time by the typical number of units.

95010 Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests

The RUC reviewed the survey results from 32 allergy and immunology physicians and determined that although the current value of 0.15 is overvalued, the service is intense as a significant reaction may occur. A work RVU of 0.11 appropriately accounts for the physician work required to perform this service. The specialty society indicated and the RUC agreed that this service is typically reported with an Evaluation and Management on the same date by the same provider as part of counseling the patient on the use of the epinephrine auto injector following the tests. Therefore, the RUC reduced the pre-service time to 7 minutes, agreed with the survey median intra-time of 10 minutes, and reduced the immediate post-service time to 2 minutes. When divided by 7 (the typical number of tests/codes reported on the same date) the time is converted to 1 minute pre-service time, 1.43 intra-service time and 0.29 immediate post service time. Therefore, the RUC took the crosswalk work RVU of 0.76 divided by 7, the typical number of tests, equaling 0.11 to arrive at an accurate work RVU per test. For further support the RUC referenced similar services 20553 *Injection(s); single or multiple trigger point(s), 3 or more muscle(s)* (work RVU = 0.75), which has the same intra-service time, 10 minutes, as the surveyed code and 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient* (work RVU = 0.76 and intra-service time = 10 minutes), which requires similar intensity and complexity as 95010. **The RUC recommends a work RVU of 0.11 for CPT Code 95010.**

95015 Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests

The RUC reviewed the survey results from 32 allergy and immunology physicians and determined that the current value of 0.15 is overvalued. The median work RVU of 1.25 divided by 20, the typical number of tests, equaling 0.06 appropriately accounts for the physician work required to perform this service. The specialty society indicated and the RUC agreed that this service is typically reported with an Evaluation and Management service on the same date by the same provider as part of counseling the patient on the use of the epinephrine auto injector following

the tests. Therefore, the RUC reduced the pre-service time to 7 minutes, agreed with the survey median intra-time of 15 minutes and reduced the immediate post-service time to 3 minutes, when divided by 20, the number of tests equals 0.35 pre-service time, 0.75 intra-service time and 0.15 immediate post service time. The RUC also compared 95015 to 96920 *Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm* (work RVU = 1.15 and intra-service time = 17 minutes) and 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* (work RVU 1.15 and intra-service time = 10 minutes) and determined the physician work required to perform these services are similar. **The Committee recommends a work RVU of 0.06 for CPT Code 95015.**

Work Neutrality

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

CPT Referral

The specialty societies indicated that codes 95010 and 95015 are almost always billed together. The RUC recommends that these services be referred to the CPT Editorial Panel to bundle. The RUC also recommends a CPT Assistant article be created for 95010 on how to correctly report this service as many radiologists are currently reporting this service.

Practice Expense

The RUC had an extensive discussion concerning the typical patient service and made revisions to the direct practice expense inputs recommended by the specialties. The RUC refined the clinical labor of codes 95010, 95015, and 95024 to reflect the work of the Evaluation and Management service typically performed with these services. The specialty societies recommended and the RUC agreed that there were no direct inputs in the facility setting for this service.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
95010	Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests	XXX	0.11
95015	Intracutaneous (intra-dermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests	XXX	0.06

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests	XXX	0.01 (No Change-Review Practice Expense Inputs Only)

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

CPT Code:95010	Tracking Number	Original Specialty Recommended RVU: 0.14
		Presented Recommended RVU: 0.14
Global Period: XXX		RUC Recommended RVU: 0.11

CPT Descriptor: Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male is referred after being treated in the emergency department for anaphylactic shock following an insect sting. The allergist orders percutaneous tests of 5 venoms and appropriate positive and negative controls for a total of 7 tests.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Physician assesses patient risk factors including history of asthma, cardiac disease and medications to determine if testing is appropriate and safe testing dose.
- Physician obtains informed consent from patient after explaining all risks, including anaphylaxis.

Description of Intra-Service Work:

- Physician gives instructions for preparation of testing dilutions.
- Physician is available in the office for entire intra-service period and checks patient periodically for both local and systemic reactions.
- Physician interprets test by viewing skin reaction compared to controls and determines if intracutaneous testing is necessary.

Description of Post-Service Work:

- Physician prepares a report for the referring physician and documents the results of the tests in the patient record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Donald W. Aaronson, MD, JD, MPH and Gary Gross, MD				
Specialty(s):	Joint Council of Allergy, Asthma & Immunology (JCAAI), American College of Allergy, Asthma & Immunology (ACAAI), the American Academy of Allergy, Asthma & Immunology (AAAAI)				
CPT Code:	95010				
Sample Size:	200	Resp N:	32	Response: 16.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	6.50	20.00	47.00
Survey RVW:		0.17	0.42	0.98	1.50
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		1.00	5.00	10.00	20.00
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:	95010	Recommended Physician Work RVU: 0.11		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		1.00	0.00	1.00
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:		1.43		
Immediate Post Service-Time:	0.29			
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
96372	XXX	0.17	RUC Time

CPT Descriptor Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95165	XXX	0.06	RUC Time	5,412,909

CPT Descriptor 1 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94010	XXX	0.17	RUC Time	1,256,953

CPT Descriptor 2 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95075	XXX	0.95	RUC Time

CPT Descriptor Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 7 % of respondents: 21.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95010	<u>Key Reference CPT Code:</u> 96372	<u>Source of Time</u> RUC Time
Median Pre-Service Time	1.00	2.00	
Median Intra-Service Time	1.43	3.00	
Median Immediate Post-service Time	0.29	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	2.72	7.00
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	2.29	2.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.43	2.00
Urgency of medical decision making	3.29	2.14

Technical Skill/Physical Effort (Mean)

Technical skill required	2.57	2.29
Physical effort required	1.71	1.43

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.86	2.57
Outcome depends on the skill and judgment of physician	3.71	2.71
Estimated risk of malpractice suit with poor outcome	4.14	3.14

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.43	2.00
Intra-Service intensity/complexity	2.57	2.00
Post-Service intensity/complexity	3.14	2.29

Additional Rationale and Comments

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

The survey data and the practice expense inputs were independently reviewed by the committees for the Joint Council of Allergy, Asthma & Immunology (JCAAI), American College of Allergy, Asthma & Immunology (ACAAI) and the

Specialty Internal Medicine	Frequency 27992	Percentage 23.68 %
Specialty Allergy/Immunology	Frequency 20961	Percentage 17.73 %

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 95010

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. N/A

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

CPT Code:95015	Tracking Number	Original Specialty Recommended RVU: 0.06
		Presented Recommended RVU: 0.06
Global Period: XXX		RUC Recommended RVU: 0.06

CPT Descriptor: Intracutaneous (intra-dermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old male is referred after being treated in the emergency department for anaphylactic shock following an insect sting. His percutaneous venom tests are negative and the allergist orders intracutaneous testing of five Hymenoptera venoms at increasing concentrations for a maximum of four sequential dilutions per venom or 20 tests.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Physician obtains informed consent from patient after explaining all risks including increased risk of anaphylaxis.
- Physician evaluates patient risk factors to determine safe starting dose.

Description of Intra-Service Work:

- Physician gives instructions for the preparation of testing dilutions.
- Physician is available in the office for entire intra-service period and checks patient periodically and before administration of each sequential set of dilutions for local and systemic reactions.
- Physician interprets tests to determine if positive or negative and if negative, whether it is safe and appropriate to administer next higher concentration.

Description of Post-Service Work:

- Physician prepares a report for the referring physician and documents the results of the tests in the patient record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2011				
Presenter(s):	Donald W. Aaronson, MD, JD, MPH and Gary Gross, MD				
Specialty(s):	Joint Council of Allergy, Asthma & Immunology (JCAAI), American College of Allergy, Asthma & Immunology (ACAAI), the American Academy of Allergy, Asthma & Immunology (AAAAI)				
CPT Code:	95015				
Sample Size:	200	Resp N:	32	Response: 16.0 %	
Sample Type:	Random	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		1.00	9.25	20.00	53.00
Survey RVW:		0.17	0.88	1.25	2.31
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		2.00	10.00	15.00	41.25
Immediate Post Service-Time:	15.00				
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:	95015	Recommended Physician Work RVU: 0.06		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		0.35	0.00	0.35
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:		0.75		
Immediate Post Service-Time:	0.15			
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95075	XXX	0.95	RUC Time

CPT Descriptor Ingestion challenge test (sequential and incremental ingestion of test items, eg, food, drug or other substance such as metabisulfite)

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95165	XXX	0.06	RUC Time	5,412,909

CPT Descriptor 1 Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
94010	XXX	0.17	RUC Time	1,256,953

CPT Descriptor 2 Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
95806	XXX	1.25	RUC Time

CPT Descriptor Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)

RELATIONSHIP OF CODE BEING REVIEWED TO KEY REFERENCE SERVICE(S):Compare the pre-, intra-, and post-service time (by the median) and the 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: 9 % of respondents: 28.1 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 95015	<u>Key Reference CPT Code:</u> 95075	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.35	15.00	
Median Intra-Service Time	0.75	30.00	
Median Immediate Post-service Time	0.15	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	1.25	60.00
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	3.44	3.44
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.00	3.67
Urgency of medical decision making	3.89	3.33

Technical Skill/Physical Effort (Mean)

Technical skill required	3.38	3.63
Physical effort required	2.25	1.88

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	4.11	4.44
Outcome depends on the skill and judgment of physician	4.11	4.00
Estimated risk of malpractice suit with poor outcome	4.33	4.33

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.44	3.78
Intra-Service intensity/complexity	3.67	3.56
Post-Service intensity/complexity	4.11	3.78

Additional Rationale and Comments

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

The survey data and the practice expense inputs were independently reviewed by the committees for the Joint Council of Allergy, Asthma & Immunology (JCAAI), American College of Allergy, Asthma & Immunology (ACAAI) and the

Specialty Otolaryngology

Frequency 2588

Percentage 5.55 %

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 95015

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. N/A

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

Global Period: XXX

CPT Long Descriptor:

95010: Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests

95015: Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests

95024: Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests

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

JCAAI, ACAAI, AAOA and AAAAI convened a consensus panel to develop recommendations for these codes. The composition of this panel included private practice and academic allergists in varying types of practices and locations.

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:

95010 Clinical Labor Activities:

Pre-Service Clinical Labor Activities:

- Venom (5) and controls (2) for a total of 7 tests are brought to the area for testing.
- Venoms for testing are mixed from lyophilized venom powders and labels are made for each venom.

Intra-Service Clinical Labor Activities:

- The skin is cleaned with alcohol and areas to be used for the tests are marked.
- A set of 5 venoms and 2 controls is applied to the skin and the skin is pricked with the device.
- The size of the wheals are measured and recorded after the monitoring period.
- The patient is monitored constantly for topical or systemic reactions.
- After the test, the patient's skin is cleaned with alcohol and, if necessary, topical steroid cream is applied.

Post-Service Clinical Labor Activities:

- The room is cleaned and supplies are put away.

95015 Clinical Labor Activities:

CPT Code: 95010, 95015 & 95024
AMA/Specialty Society RVS Update Committee Recommendation

Pre-Service Clinical Labor Activities:

- Labels are made for 20 vials and syringes for the intradermal tests.
- Dilutions are made for intradermal testing

Intra-Service Clinical Labor Activities:

- The skin is cleaned with alcohol and areas to be used for the tests are marked.
- The first set of intracutaneous tests are applied.
- Subsequent sets of intracutaneous tests are applied as directed by the physician up to a total of four sets of dilutions.
- The size of the wheal is measured and recorded after the monitoring period for each injection.
- Patient is monitored constantly for topical and systemic reactions.
- After the physician has read and evaluated the skin test reactions, the sites are cleaned with alcohol and if necessary, topical steroid cream is applied.

Post-Service Clinical Labor Activities:

- The room is cleaned and supplies are put away.

95024 Clinical Labor Activities:

Pre-Service Clinical Labor Activities:

- Labels are made for 16 vials and syringes for the intradermal tests.
- Dilutions are made for intradermal testing

Intra-Service Clinical Labor Activities:

- The skin on the arm is cleaned with alcohol and the sites are marked for testing with the first concentration of the five venoms.
- Intracutaneous tests are applied. Each site is measured (wheal and flare) after the monitoring period.
- After the physician has read and evaluated the skin test reactions, the sites are cleaned with alcohol and if necessary, topical steroid cream is applied.

Post-Service Clinical Labor Activities:

- The room is cleaned and supplies are put away.

Code 95010—Explanation of PE Changes

The following is an explanation for each of the changes.

Prepare testing board and testing syringes. Our experts indicate that it takes about 15 minutes to complete this task when preparing for testing 7 venoms. Divided by 7 tests, this would result in a per test estimate of 2.143 minutes. The preparations are made on the day of the test.

Greet patient, ensure appropriate medical records are available. Our new estimate for this is based off of the PE Standard for greeting the patient, which is 3 minutes. Divided by 7 tests, this would result in a per test estimate of 0.429 minutes.

Prepare room, equipment and supplies. Our new estimate for this is based off of the PE Standard for preparing a room, equipment and supplies, which is 2 minutes. Divided by 7 tests, this would result in a per test estimate of 0.286 minutes.

CPT Code: 95010, 95015 & 95024
AMA/Specialty Society RVS Update Committee Recommendation

Perform Procedure. The experts estimate that it takes 10 minutes to administer 7 percutaneous tests. Divided by 7 tests, this would result in a per test estimate of 1.429 minutes.

Monitor Patient. The panel believes that 15 minutes is required for monitoring the patient. Divided by 7 tests, this would result in a per test estimate of 2.143 minutes.

Clean room/equipment by physician staff. Our new estimate for this is 1 minute, which is lower than the PE Standard for cleaning of the room and equipment, which is 3 minutes. Dividing 1 minute by 7 tests, this would result in a per test estimate of 0.143 minutes.

Education/Instruction/Counseling. Our new estimate for this is that the clinical labor staff spends 5 minutes providing Education/Instruction/Counseling to the patient. Divided by 7 tests, this would result in a per test estimate of 0.714 minutes.

Charting. We estimate that charting for 7 percutaneous tests takes 3.5 minutes. Dividing by 7 tests, our panel is recommending a per test time for charting of 0.500 minutes.

These changes would increase total clinical time from 7.289 minutes to 7.786 minutes.

Supplies

Supplies that are no longer used have been eliminated from the supplies list. The bifurcated needle is now used instead of a multi-tine device. 0.5 ml of venom is used when performing 7 tests (0.071 when divided by 7 tests).

Equipment

No equipment is assigned.

Code 95015—Explanation of PE Changes

Based on CMS data showing that the typical number of allergy tests performed under Code 95015 is higher than had been previously assumed, JCAAI, ACAAI, AAOA and AAAAI convened a panel of experts to review and revise the direct cost inputs. We are now assuming that the typical number of tests performed is 20 as compared with 12 which was previously assumed. This is based on 2009 CMS data using the median as opposed to the arithmetic mean. The median is of course a much better representation of typicality and assures that the impact of high and low outliers are minimized.

The following is an explanation for each of the changes.

Prepare testing board and testing syringes. Our experts indicate that it takes about 25 minutes to complete this task when preparing for testing 20 antigens. Divided by 20 tests, this would result in a per test estimate of 1.250 minutes. The preparations are made on the day of the test.

Prepare room, equipment and supplies. Our new estimate for this is based off of the PE Standard for preparing a room, equipment and supplies, which is 2 minutes. Divided by 20 tests, this would result in a per test estimate of 0.100 minutes.

CPT Code: 95010, 95015 & 95024
AMA/Specialty Society RVS Update Committee Recommendation

Perform Procedure. The experts estimate that it takes 30 minutes to administer 20 intradermal tests. Divided by 20 tests, this would result in a per test estimate of 1.500 minutes.

Monitor Patient. The panel believes that 30 minutes is required for monitoring the patient. Divided by 20 tests, this would result in a per test estimate of 1.500 minutes.

Clean room/equipment by physician staff. Our new estimate for this is based off of the PE Standard for cleaning of the room and equipment, which is 3 minutes. Divided by 20 tests, this would result in a per test estimate of 0.150 minutes.

Education/Instruction/Counseling. Our new estimate for this is that the clinical labor staff spends 5 minutes providing Education/Instruction/Counseling to the patient. Divided by 20 tests, this would result in a per test estimate of 0.250 minutes.

Charting. We estimate that charting for 20 intradermal tests takes 10 minutes. Dividing by 20 tests, our panel is recommending a per test time for charting of 0.500 minutes.

Conduct phone calls/call in prescriptions. Our new estimate for this is that the clinical labor staff spends 3 minutes conducting phone calls. Divided by 20 tests, this would result in a per test estimate of 0.150 minutes.

These changes would increase total clinical time from 3.113 minutes to 5.400 minutes.

Supplies

We have adjusted the per unit supplies by amortizing the supplies used for a typical battery of tests over 20 as opposed to 12 tests. Supplies that are no longer used have been eliminated from the supplies list.

Equipment

No equipment is assigned.

Code 95024—Explanation of PE Changes

Based on CMS data showing that the typical number of allergy tests performed under Code 95024 is higher than had been previously assumed, JCAAI, ACAAI, AAOA and AAAAI convened a panel of experts to review and revise the direct cost inputs. We are now assuming that the typical number of tests performed is 16 as compared with 12 which was previously assumed. This is based on 2009 CMS data using the median as opposed to the arithmetic mean. The median is of course a much better representation of typicality and assures that the impact of high and low outliers are minimized.

The following is an explanation for each of the changes.

Prepare testing board and testing syringes. Our experts indicate that it takes about 0.5 minutes to complete this task for each antigen tested. Thus, we are not changing the time assigned to this activity. The preparations are made before the patient arrives.

CPT Code: 95010, 95015 & 95024
AMA/Specialty Society RVS Update Committee Recommendation

Greet patient, ensure appropriate medical records are available. Our new estimate for this is based off of the PE Standard for greeting the patient, which is 3 minutes. Divided by 16 tests, this would result in a per test estimate of 0.188 minutes.

Prepare room, equipment and supplies. Our new estimate for this is based off of the PE Standard for preparing a room, equipment and supplies, which is 2 minutes. Divided by 16 tests, this would result in a per test estimate of 0.125 minutes.

Perform Procedure. The current estimate assumes it takes 0.75 minutes to administer each intradermal test. We think this estimate is still valid and does not change because of a change in the typical number of tests.

Monitor Patient. The current estimate of 0.4 minutes is based on the judgment that 5 minutes are spent monitoring the patient to see reactions, etc. The panel believes the 5 minute estimate is about right and dividing that time by 16 tests would result in a per test estimate of 0.313 per test.

Clean room/equipment by physician staff. Our new estimate for this is based off of the PE Standard for cleaning of the room and equipment, which is 3 minutes. Divided by 16 tests, this would result in a per test estimate of 0.188 minutes.

Education/Instruction/Counseling. Our new estimate for this is that the clinical labor staff spends 5 minutes providing Education/Instruction/Counseling to the patient. Divided by 16 tests, this would result in a per test estimate of 0.313 minutes.

Charting. The current estimate of 0.166 per test was based on the estimate that 2 minutes are spent on this activity recording reactions, etc. is too low. We estimate that this takes 8 minutes. Dividing by 16 tests, our panel is recommending a per test time for charting of 0.500 minutes.

Conduct phone calls/call in prescriptions. Our new estimate for this is that the clinical labor staff spends 3 minutes conducting phone calls. Divided by 16 tests, this would result in a per test estimate of 0.188 minutes.

These changes would increase total clinical time from 2.236 minutes to 3.063 minutes.

Supplies

We have adjusted the per unit supplies by amortizing the supplies used for a typical battery of tests over 16 as opposed to 12 tests. 3 concentrations are used per test, requiring 3 syringes, 3 needles and 3 alcohol swabs. A drape is used for the patient as the tests are performed on the patients back. Supplies that are no longer used have been eliminated from the supplies list.

Equipment

No equipment is assigned.

	A	B	C	D	E	F	G	H	I	J	K	L
1	AMA Specialty Society RVS Update Committee Recommendation			95010			95015			95024		
2	Meeting Date: 2011			Percutaneous tests (scratch, puncture, prick) sequential and			Intracutaneous (intradermal) tests, sequential and incremental, with			Intracutaneous (intradermal) tests with allergenic extracts, immediate type		
3		CMS	Staff	Non Facility (existing; 2002 data)	Non Facility (Proposed 2012)	TOTAL (Prop. 2012)	Non Facility (existing; 2002 data)	Non Facility (Proposed 2012)	TOTAL (Prop. 2012)	Non Facility (existing; 2007 data)	Non Facility (Proposed 2012)	TOTAL (Prop. 2012)
4		Code	Type	# of Tests per test	Value Derived From	7	per test	per test	20	per test	per test	16
5	LOCATION			7 tests	7 tests		12 tests	20 tests		12 tests	16 tests	
6	GLOBAL PERIOD			XXX	XXX	XXX	XXX	XXX		XXX	XXX	
7	TOTAL CLINICAL LABOR TIME	L037D	RN/LPN/MTA	7.289	4.572	32	3.113	3.611	72	2.236	1.849	30
8	TOTAL PRE-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	3.000	0.000	0	0.000	0.000	0	0.500	0.500	8
9	TOTAL SERVICE PERIOD CLINICAL LABOR TIME	L037D	RN/LPN/MTA	4.289	4.572	32	3.113	3.611	72	1.486	1.349	22
10	TOTAL POST-SERV CLINICAL LABOR TIME	L037D	RN/LPN/MTA	0.000	0.000	0	0.000	0.000	0	0.250	0.000	0
11	PRE-SERVICE											
12	Start: Following visit when decision for surgery or procedure made											
13	Prep testing board, testing syringes	L037D	RN/LPN/MTA	3						0.500	0.500	8
14	End: When patient enters office/facility for surgery/procedure											
15	SERVICE PERIOD											
16	Start: When patient enters office/facility for surgery/procedure: Services Prior to Procedure											
17	Prep testing board, testing syringes	L037D	RN/LPN/MTA		2.143	15.0		1.250	25.0			
18	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA		0.000	0.0		0.000	0.0		0.000	0.0
19	Obtain Vital Signs (3 vital signs)				0.000	0.0		0.000	0.0		0.000	0.0
20	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.857	0.000	0.0		0.000	0.0		0.000	0.0
21	Prepare room, equipment, supplies	L037D	RN/LPN/MTA	0.429	0.000	0.0		0.000	0.0		0.000	0.0
22	Prepare and position patient	L037D	RN/LPN/MTA	0.429	0.000	0.0	0.250	0.000	0.0	0.170	0.000	0.0
23	Intra-service											
24	Performing procedure	L037D	RN/LPN/MTA	0.429	0.500	3.5	1.000	1.500	30.0	0.750	0.500	8.0
25	Monitor Patient	L037D	RN/LPN/MTA	1.43	1.500	10.5	1.330	0.525	10.5	0.400	0.500	8.0
26	Post-Service											
27	Clean room/equipment by physician staff	L037D	RN/LPN/MTA		0.143	1.0	0.200	0.050	1.0		0.063	1.0
28	Education/Instruction/Counseling	L037D	RN/LPN/MTA	0.429	0.000	0.0	0.200	0.000	0.0		0.000	0.0
29	Charting	L037D	RN/LPN/MTA	0.286	0.286	2.0	0.133	0.286	5.7	0.166	0.286	4.6
30	End: Patient leaves office											
31	POST-SERVICE Period											
32	Start: Patient leaves office/facility											
33	Conduct phone calls/call in prescriptions	L037D	RN/LPN/MTA		0.000	0.000		0.000	0.0	0.250	0.000	0.0
34	MEDICAL SUPPLIES											
35	pack, minimum multi-sof-setspecialty visit	SA048	pack				0.070	0.000	0.0	0.083	0	0.0
36	cover, thermometer probe	SB004	item	0.140	0.000	0.0			0.0			0.0
37	drape, non-sterile, sheet 40in x 60in	SB006	item			0.0	0.100	0.050	1.0		0.063	1.0
38	gloves, non-sterile	SB022	pair	0.140	0.286	2.0		0.200	4.0		0.125	2.0
39	multi-tine device	SC023	item	1.000	0.000	0.0			0.0			0.0
40	bifurcated needle or stylet (replaces multitine device) (\$0.73 per needle)		item		1.000	7.0			0.0			0.0
41	needle, 18-27g	SC029	item			0.0	4.000	1.200	24.0		3.000	48.0
42	syringe 1ml	SC052	item	1.000	0.000	0.0	0.070	1.200	24.0	0.080	3.000	48.0
43	bandage, strip 0.75in x 3in (Bandaid)	SG021	item			0.0	0.500	0.000	0.0			0.0
44	gauze, non-sterile 2in x 2in	SG050	item	0.286	0.286	2.0	0.140	0.140	2.8	0.167	0.125	2.0
45	albumin saline	SH004	ml	5.000	5.000	35.0	1.000	0.000	0.0	1.000	1.000	16.0
46	antigen, mite	SH006	ml			0.0			0.0	1.000	1.000	16.0
47	antigen, single	SH008	ml	1.000	0.000	0.0			0.0			0.0
48	antigen, venom	SH009	ml		0.071	0.5	0.300	0.025	0.5			0.0
49	triamcinolone acetone 0.1% cream	SH072	gm	0.140	0.140	1.0	0.020	0.050	1.0	0.125	0.063	1.0
50	swab-pad, alcohol	SJ053	item	0.140	3.000	21.0	0.140	1.400	28.0	0.170	3.000	48.0
51	color coded cap and vial (for antigen)	SL027	item	1.000	1.000	7.0	1.000	1.000	20.0	1.000	1.000	16.0
52	label for microscope slides (label for vials)	SL085	item			0.0	1.000	1.000	20.0	1.000	1.000	16.0
53	Equipment											
54	No Equipment	EZ007		0	0		0	0		0	0	
55												
56												
57												
58												

AMA/Specialty Society RVS Update Committee
Diagnostic Cardiac Catheterization
Approved by RUC – April 29, 2011

Members Present

Marc Raphaelson, MD (Chair) Michael Bishop, MD, Scott Collins, MD, Brenda Lewis, DO, Douglas Leahy, MD, Scott Manaker, MD, Lawrence Martinelli, MD, Peter Smith, MD, Arthur Traugott, MD

The Workgroup met several times via conference call and face-to-face to discuss the request made by CMS pertaining to the Diagnostic Cardiac Catheterization Services. As stated in the *Final Rule* published on November 29, 2010,

To develop the RVUs for comprehensive diagnostic cardiac catheterization services, the AMA RUC generally recommended the lower of either the sum of the current RVUs for the component services or the physician survey 25th percentile value. In most cases, the AMA RUC's recommendation for the comprehensive service was actually the sum of the current work RVUs for the component services and we are unsure how this approach is resource-based with respect to physician work. We are also concerned that the physician survey appears to have overstated the work for these well established procedures so significantly that the 25th percentile value was usually higher than the sum of the current RVUs for the component services. Under this methodology, the AMA RUC-recommended RVUs for the comprehensive codes for diagnostic cardiac catheterization are an average of only one percent lower than the sum of the RVUs for the component services (taking into consideration any MPPR that would currently apply) included in the bundle. We do not find the AMA RUC's methodology or the resulting values in this case to be acceptable for a major code refinement exercise of this nature.

If we were to accept the AMA RUC's recommended values for these cardiac catheterization codes, we essentially would be agreeing with the presumption that there are negligible work efficiencies gained in the bundling of these cardiac catheterization services. On the contrary, we believe that the AMA RUC did not fully consider or account for the efficiency gains when the component services are furnished together, including the significant reduction in service time. Rather, the AMA RUC appears to have considered only the summation of the component services to the comprehensive service. **Therefore, we are requesting that the AMA RUC reexamine these codes as quickly as possible, given the significant PFS utilization and spending for cardiac catheterization services, and put forward an alternative approach to valuing these services that would produce relative values that are resource-based and do not rely predominantly on the current component service values in a circular rationale.**

Since we believe that the new comprehensive diagnostic cardiac catheterization codes would be overvalued under the AMA RUC's CY 2011 recommendations, we have employed an interim methodology to determine alternative values for these services which we are assigning as the interim final work RVUs for CY 2011. To account for efficiencies inherent in bundling, we set the work RVUs for

all of the CY 2011 cardiac catheterization codes for which we received AMA RUC recommendations to 10 percent less than the sum of the current work RVUs for the component codes, taking into consideration any MPPR that would apply under current PFS policy. We recognize that this interim methodology is not highly specific and further acknowledge that the use of another approach by the AMA RUC may have differential effects on the values of the new comprehensive services compared to the proportionate reduction on the sum of the RVUs for the component services that we have adopted as a temporary methodology.

However, given the complexity of the component code combinations that contribute to the comprehensive cardiac catheterization codes and the apparent overstatement of physician work from the physician survey, we are unable to present a more refined, code-specific methodology for the interim final values. Instead, based upon a very conservative estimate of the work efficiencies we would expect to be present when multiple component services are bundled together into a single comprehensive service, we have set interim final work values for the cardiac catheterization codes using a 10 percent reduction on the current values.

As points of comparison, we note that the current MPPR policies under the PFS for imaging and surgical services reduce payment for the second and subsequent procedures by 50 percent on the TC and complete service, respectively, and, as discussed in detail in section II.C.4. of this final rule with comment period, we are adopting a 25 percent MPPR on the PE component of payment for therapy services in CY 2011. We further note that the service specific work efficiencies for the other two major categories of new bundled codes for CY 2011, specifically endovascular revascularization and CT, are generally between 20 and 35 percent.

In January 2011, the Workgroup reviewed the RUC recommendations for Diagnostic Cardiac Catheterization Services that were sent to CMS in May 2010.

- For the 20 codes in the series, RUC recommended values were at the survey 25th percentile for 5 codes, below the 25th percentile for 8 codes, and between the 25th and 50th percentile for 7 codes.
- For the 20 codes in the series, RUC recommended values were at current values for 11 codes, below the current values for 3 codes, and above current values for 3 codes. The 3 remaining codes were newly evaluated and did not have current value assignments for comparison.
- The Workgroup noted that neither CMS nor specialty societies challenged the RVUs or times during the first three 5-year reviews.

Medicare Budget impact estimations demonstrated an overall savings of about 3.7% for work RVUs for the entire series. The reference service list supported these valuations, but the list was somewhat limited, because a number of comparative services were then under RUC review. The Workgroup reached consensus that these recommendations were resource based and followed the RUC's current process and policies of establishing RVUs for new/revised services as they were based on magnitude estimation and building block and were reviewed for potential rank order anomalies. To address the concerns raised by CMS, the Workgroup requested the following information from the specialty society:

1. The Workgroup requests that the specialty society provide the Workgroup the valuation history for all of the new bundled cardiac catheterization services utilizing the above format. Further, the Workgroup requests that the specialty society provide the Workgroup the historical service times for the bundled cardiac catheterization services.
2. The Workgroup requests that the specialty societies provide information supporting this shift in patient population to the Workgroup to further validate the RUC recommended values for these services.
3. The Workgroup requests that the specialty societies review pre, post and intraservice work for each of the bundled codes, to help determine what duplication might be present when services are bundled.
4. The Workgroup requests that the specialty societies provide alternative reference codes to support the RUC recommended values for each of the bundled diagnostic cardiac catheterization services.

During the March 2011 conference call, the specialty society presented the data requested by the Workgroup.

First, the Workgroup reviewed the CMS assumption that when services are bundled together, there should be substantial efficiencies in total work RVUs and times. The Workgroup, through its review of the valuation history of the Diagnostic Cardiac Catheterization services, respectfully disagreed with this assumption for these services.

The valuation history for the diagnostic cardiac catheterization codes begins in 1993. In 1993, several of the high volume diagnostic cardiac catheterization codes could be reported either through a bundled mechanism or a component coding mechanism. Component coding allowed a radiologist to bill for supervision and interpretation of the procedure, while the cardiologist billed for the catheterization. CMS valuation for the service was virtually identical whether services were reported as a single code or as components. In 1994, the bundled diagnostic cardiac catheterization codes were deleted and a new component coding structure was designed. Between 1994 and 2010, the valuation for the component coding for these services were subject to minor adjustments that were applied to all values within the RBRVS. Modifications in multiple procedure payment policy also affected valuation of these codes. The following is an example of the valuation history for a left heart catheterization combination service between 1993 and 2010:

93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed			
	1993 Bundled RVUs	6.32	1993 Bundled Physician Time	151
	1993 Component RVUs	6.31	1993 Component Physician Time	223
	1994 Component RVUs	6.62	1994 Component Physician Time	245
	2010 Component RVUs	6.51*	2010 Component Physician Time	210
	2011 Bundled RVUs (RUC recommended)	6.51	2011 Bundled Physician Time	123

*Valuation subject to Multiple Procedure Reduction Policy which went into effect in 1995

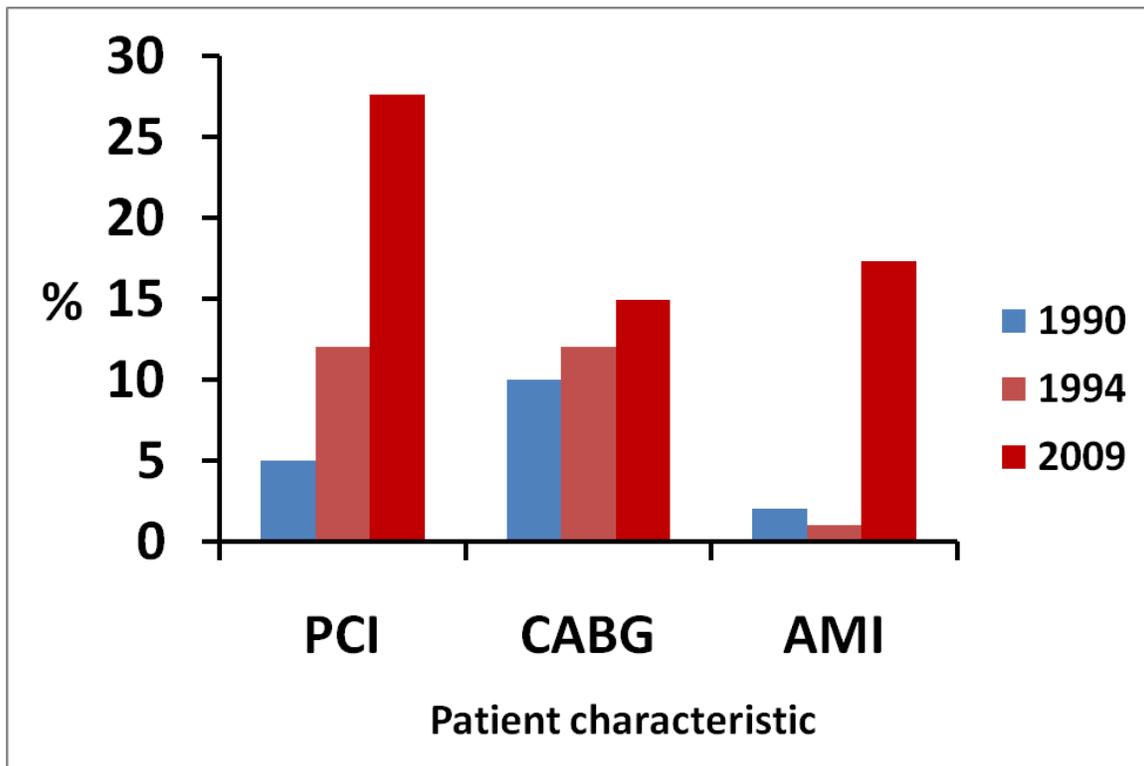
Utilizing the data from the example above, the Workgroup noted that whether the left heart catheterization combination of services was reported as a bundled service or as component services the work RVU was relatively constant over 18 years, despite the variations in service times assigned by CMS without RUC survey. The Workgroup reviewed similar specific historic data for each of the diagnostic cardiac catheterization services that had bundled and component coding in 1993 [Attachment #1]. Each demonstrated stable RVU valuation whether reported as a bundled code or multiple codes in 1993 and stable valuation when reported as multiple codes thereafter, even when assigned times were altered. The Workgroup agrees with CMS that any excessive valuation introduced in the 1994 unbundling should be subtracted in the 2010 rebundling. However, since no excessive valuation was assigned when component coding was introduced, there is no obvious excessive valuation to remove while rebundling the same codes for the same procedures.

The Workgroup agreed that this valuation history suggests that CMS concluded that there should be no duplication in the valuation of these services when reported by component coding as opposed to bundled coding in the initiation of the RBRVS. The RUC's recommendations for these services in 2010, reaffirm this conclusion.

RUC valuation for a number of the cardiac catheterization codes include stable RVUs with lower total and intra-service times. The Workgroup reviewed the historical times for these services as provided by the specialty society [attachment #1] and made several observations. First and foremost, the Workgroup agreed that the source of the historical times may be inaccurate, as these service times were derived from Harvard times and CMS estimates rather than physician surveys. The Workgroup noted that RUC surveys are deemed by CMS to be more accurate than older methods; indeed, absence of RUC valuation is now a sufficient reason for CMS to request RUC evaluation of codes commonly performed. Additionally, the Workgroup acknowledged that currently there is much more emphasis on accuracy of physician time than at the beginning of the RBRVS. Finally, the Workgroup notes that subsequent to the adoption of standard pre-service time packages, pre-service time often has decreased for RUC valued services. This standardization further contributed to reduced preservice times for the current valuation of the cardiac catheterization codes. The Workgroup contends that the times originally assigned to these services were incorrect and that the time collected from the physicians who participated in the 2010 RUC surveys is more accurate. It is very important to note that there has not been a process established to merely correct time from old Harvard data and/or CMS. The processes (Five-Year Reviews) have focused on the accuracy of the work values.

Second, the Workgroup discussed the change in the intensity of providing cardiac catheterization. The specialty societies provided evidence that the typical patient currently is more likely to be an inpatient and is more likely to have suffered a heart attack than the patients in the past. Expert opinion is supplemented by data from the *Registry of the Society for Cardiac Angiography and Interventions*, which demonstrates that the percentage of patients receiving diagnostic cardiac catheterization services, had undergone previous PCI or CABG or had an AMI within the past 24 hours is higher in 2009 than in the early 90's. [Figure A]

Figure A: Data from the Registry of the Society for Cardiac Angiography and Interventions



Further, a peer reviewed publication, *Chest*, in 2007, found that patients having coronary angioplasty in 2005 are older and have a higher prevalence of diabetes, hypertension and higher BMI than those in 1996. Additionally, the specialty society indicated that the work of the procedure has become more complex, partly because current catheters are smaller and more difficult to manipulate in comparison to the larger catheters used in the early 90's. The Workgroup agrees with the specialty society that the work of diagnostic cardiac catheterization has not decreased. that the RUC recommendations for cardiac catheterization are appropriate and no further decreases to the RUC recommended work RVUs could be substantiated.

Third, the Workgroup reviewed a revised and expanded list of reference codes document [attachment #2] as provided by the specialty societies. This list includes codes valued by RUC while the cardiac catheterization codes were under review, codes whose values are now published by CMS. Valuation for each code in this family is supported by values of other RUC surveyed codes requiring similar work. This method of magnitude estimation further supports the RUC recommended values for the diagnostic cardiac catheterization services.

The Workgroup was charged with addressing CMS' concerns with the RUC recommended work RVUs for Diagnostic Cardiac Catheterization Services through a re-review of RUC recommendations. Based on historical analysis of work RVUs and times, on evidence that the work of cardiac catheterization services has not decreased, and on comparisons to services requiring similar work, the Workgroup submits that the RUC recommendations for each of these services were derived through magnitude estimation, are resource-based and support the CMS conclusion from 1993 that there is negligible duplication in work or valuation, whether these services are reported as individual component codes or as a bundle. **The Workgroup reaffirms the RUC's recommended values for the diagnostic cardiac catheterization services.**

Alternate Reference ACC Tab 36

CPT Code		Descriptor	Pre-time	Intra-time	Post-time	Total Time	RVU	Global
31256	Ref	Nasal/sinus endoscopy, w/ max anrostomy	33	45	18	96	3.29	000
77786	Ref	high dose rate radionuclide brachytherapy	14	60	15	89	3.25	000
43458	Ref	Dilate espophagus/30 mm> for achalasia	21	31	30	82	3.06	000
93451	RUC REC	RHC w/wo O2 sat & CO	48	30	30	108	3.02	000
95974	Ref	neurostimulator pulse gen complex	30	60	20	110	3.00	XXX
62267	Ref (CC)	Interdiscal perq aspir dx	34	30	15	79	3.00	000
93503	SVY Ref Code	Insert Swan-Ganz monitoring	12	15	10	37	2.91	000
31623	Ref	Dx bronchoscope/brush	20	30	20	70	2.88	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
93624	SVY Ref Code	EP follow up w/pacing inc induct arrhy	30	60	38	128	4.80	000
31288	Ref	Nasal/sinus endoscopy	30	60	30	120	4.57	000
50385	Ref	Rmv/replace of intern ureteral stent	49	45	15	109	4.44	000
93452	RUC REC	LHC for LVG	48	30	30	108	4.32	000
49418	Ref	tnld intraperitoneal catheter, compl	44	40	20	104	4.21	000
31629	Ref (CC)	Bronchoscopy/needle bx each	30	30	20	80	4.09	000
31634	Ref	Bronchoscopy, including fluor guidance	25	45	20	90	4.00	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
31600	Ref (CC)	Tracheostomy, planned (sep proc.)	50	40	55	145	7.17	000
52282	Ref	Cystourethroscopy, w/ ins of perm utr stent	40	50	30	120	6.39	000
43261	Ref	(ERCP); with biopsy, single or multiple	20	55	20	95	6.26	000
58563	Ref	Hysteroscopy, surg; w/endometrial abl	40	60	30	130	6.16	000
52277	Ref	Cystourethroscopy, sphincterotomy	45	45	40	130	6.16	000
36561	Ref	Insrt tunel'd CVA device, w/subcu pt	35	45	50	130	6.04	010
93453	RUC REC	R+LHC wo cors eg ped wMR	48	45	30	123	5.98	000
45387	Ref (CC)	Colonoscopy w/stent	30	45	30	105	5.90	000
31267	Ref	Nasal/sinus endoscopy	30	50	30	110	5.45	000
59074	Ref	Fetal fluid drainage w/us	65	30	30	125	5.24	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
93619	SVY Ref Code	EP right atrial pacing	60	90	53	203	7.31	000
59074	Ref	Fetal fluid drainage w/us	65	30	30	125	5.24	000
45385	Ref&MPC (CC)	Colonoscopy, flexible	16	43	15	74	5.30	000
45391	Ref	Colonoscopy, with endoscope, us	35	55	20	110	5.09	000
93454	RUC REC	CORS	48	30	30	108	4.95	000
11011	Ref-New	Debrid rmv foreign OF; subc	45	60	45	150	4.94	000
31288	Ref	Nasal/sinus endoscopy	30	60	30	120	4.57	000
50385	Ref	Rmv/replace of intern ureteral stent	49	45	15	109	4.44	000
31629	Ref	Bronchoscopy/needle bx each	30	30	20	80	4.09	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
93619	SVY Ref Code	EP right atrial pacing	60	90	53	203	7.31	000
34812	Ref&MPC (CC)	Xpose endoprosth fem, unilateral	75	45	30	150	6.74	000
52282	Ref	Cystourethroscopy, w/ ins of perm utr stent	40	50	30	120	6.39	000
43261	Ref	(ERCP); with biopsy, single or multiple	20	55	20	95	6.26	000
52277	Ref	Cystourethroscopy, sphincterotomy	45	45	40	130	6.16	000
93455	RUC REC	CORS + Grafts	53	40	30	123	6.15	000
45387	Ref	Colonoscopy w/stent	30	45	30	105	5.90	000
45385	Ref&MPC	Colonoscopy, flexible	16	43	15	74	5.30	000
CPT Code		Descriptor	Pre-time	Intra-time	Post-time	Total Time	RVU	Global
37187	SVY Ref Code	Venous mechanical thrombectomy	40	85	20	145	8.02	000
43261	Ref (CC)	(ERCP); with biopsy, single or multiple	20	55	20	95	6.26	000
93456	RUC REC	RHC + CORS	48	40	30	118	6.00	000
45387	Ref	Colonoscopy w/stent	30	45	30	105	5.90	000
31267	Ref	Nasal/sinus endoscopy	30	50	30	110	5.45	000
45385	Ref&MPC	Colonoscopy, flexible	16	43	15	74	5.30	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code

Alternate Reference ACC Tab 36

37184	SVY Ref Code	Prime Art Mech thrombectomy	40	90	30	160	8.66	000
37183	Ref	Remove Hepatic Shunt (TIPS)	28	78	30	135	7.99	000
32603	Ref	Thoracoscopy, diagnostic w/o biopsy	83	90	120	293	7.80	000
93457	RUC REC	RHC + CORS + Grafts	53	50	30	133	7.66	000
52345	Ref (CC)	Cysto/uretero w/up stricture	70	45	20	135	7.55	000
52344	Ref	Cysto/uretero balloon dilation	60	45	20	125	7.05	000
75956	Ref	X Ray Endovascular repair	30	90	20	140	7.00	XXX
43261	Ref	(ERCP); with biopsy, single or multiple	20	55	20	95	6.26	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
93619	SVY Ref Code	EP right atrial pacing	60	90	53	203	7.31	000
11012	Ref	Deb skin bone at fx site	60	90	60	210	6.87	000
43240	Ref	U GI endoscopy	20	90	20	130	6.85	000
34812	Ref&MPC (CC)	Xpose endoprosth fem, unilateral	75	45	30	150	6.74	000
93458	RUC REC	CORS + LVG	48	45	30	123	6.51	000
43261	Ref	(ERCP); with biopsy, single or multiple	20	55	20	95	6.26	000
45387	Ref	Colonoscopy w/stent	30	45	30	105	5.90	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
37184	SVY Ref Code	Prime Art Mech thrombectomy	40	90	30	160	8.66	000
52345	Ref	Cysto/uretero w/up stricture	70	45	20	135	7.55	000
93459	RUC REC	CORS + Grafts + LHC	53	50	30	133	7.34	000
31600	Ref (CC)	Tracheostomy, planned (sep proc.)	50	40	55	145	7.17	000
52344	Ref	Cysto/uretero balloon dilation	60	45	20	125	7.05	000
75956	Ref	X Ray Endovascular repair	30	90	20	140	7.00	XXX
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
37184	SVY Ref Code	Prime Art Mech thrombectomy	40	90	30	160	8.66	000
37183	Ref	Remove Hepatic Shunt (TIPS)	28	78	30	135	7.99	000
37235	Ref	TIB/per Revasc Stnt/Ather	1	80	1	82	7.80	ZZZ
93460	RUC REC	RHC + CORS + LVG	48	50	30	128	7.88	000
52345	Ref	Cysto/uretero w/up stricture	70	45	20	135	7.55	000
31600	Ref (CC)	Tracheostomy, planned (sep proc.)	50	40	55	145	7.17	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
93620	SVY Ref MPC	Comp EP w/reposit, induct arrhy RA pac	60	120	60	240	11.57	000
35475	Ref	Transl balloon angioplasty	0	90	121	211	9.47	000
37224	Ref	Endov, fem, unil, w.translum angio	48	80	30	158	9.00	000
93461	RUC REC	R & L CORS & Grafts	53	65	35	153	9.00	000
59076	Ref (CC)	Fetal Shunt Placement w/us	105	60	0	165	8.99	000
37220	MPC	Revasc, iliac, unil, init ves, w/translum angio	48	60	30	138	8.15	000
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
13133	Ref (CC) MPC	Repair, cmplx, head/neck/feet, add <5 cm	0	30	0	30	2.19	ZZZ
15151	Ref (CC)	Tissue epiderm autogft ; add1-75 sq cm	0	20	0	20	2.00	ZZZ
93563	RUC REC	Inj, selective COR Angio	0	25	0	25	2.00	ZZZ
92978	SVY Ref Code	Intravasc US (cor vessel/graft) init vessel	0	25	0	25	1.80	ZZZ
15005	Ref	Wnd prep F/N/HF/G add on	0	20	1	21	1.60	ZZZ
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
13133	Ref (CC) MPC	Repair, cmplx, head/neck/feet, add <5 cm	0	30	0	30	2.19	ZZZ
37250	Ref	IV US 1st Vessel Add on	0	23	0	23	2.10	ZZZ
93564	RUC REC	Inj, selective opac bypass graft	0	25	0	25	2.10	ZZZ
15151	Ref (CC)	Tissue epiderm autogft ; add1-75 sq cm	0	20	0	20	2.00	ZZZ
92978	SVY Ref Code	Intravasc US (cor vessel/graft) init vessel	0	25	0	25	1.80	ZZZ
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
13133	Ref (CC) MPC	Repair, cmplx, head/neck/feet, add <5 cm	0	30	0	30	2.19	ZZZ
15151	Ref (CC)	Tissue epiderm autogft ; add1-75 sq cm	0	20	0	20	2.00	ZZZ
93565	RUC REC	Inj, selective, LV or LAG	0	20	0	20	1.90	ZZZ
92978	SVY Ref Code	Intravasc US (cor vessel/graft) init vessel	0	25	0	25	1.80	ZZZ
11047	Ref	Debrid Bone Add on	0	30	1	31	1.20	ZZZ
96570	Ref	Photodynamc tx 30 min add-on	0	30	0	30	1.1	ZZZ
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code

Alternate Reference ACC Tab 36

15151	Ref (CC)	Tissue epiderm autogft ; add1-75 sq cm	0	20	0	20	2.00	ZZZ
11047	Ref	Debrid Bone Add on	0	30	1	31	1.20	ZZZ
96570	Ref	Photodynamc tx 30 min add-on	0	30	0	30	1.1	ZZZ
93566	RUC REC	Inj, RV or RT atrial angio	0	20	0	20	0.96	ZZZ
93015	SVY Ref Code	Stress test	2	15	4	21	0.75	XXX
15301	Ref	Apply sknalogrft t/a/l addl	0	15	0	15	1.00	ZZZ
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
92978	SVY Ref Code	Intravasc US (cor vessel/graft) init vessel	0	25	0	25	1.80	ZZZ
11047	Ref	Debrid Bone Add on	0	30	1	31	1.20	ZZZ
96570	Ref	Photodynamc tx 30 min add-on	0	30	0	30	1.1	ZZZ
93567	RUC REC	Inj, supra-avalvular aortography	0	15	0	15	0.97	ZZZ
99213	Ref & MPC(CC)	E&M 2 of 3, 15 min face to face	3	15	5	23	0.97	XXX
15301	Ref	Apply sknalogrft t/a/l addl	0	15	0	15	1.00	ZZZ
CPT Code	CPT Code	CPT Code	CPT Cod	CPT Cod	CPT Cod	CPT Code	CPT Code	CPT Code
15151	Ref (CC)	Tissue epiderm autogft ; add1-75 sq cm	0	20	0	20	2.00	ZZZ
92978	SVY Ref Code	Intravasc US (cor vessel/graft) init vessel	0	25	0	25	1.80	ZZZ
11047	Ref	Debrid Bone Add on	0	30	1	31	1.20	ZZZ
96570	Ref	Photodynamc tx 30 min add-on	0	30	0	30	1.1	ZZZ
15301	Ref	Apply sknalogrft t/a/l addl	0	15	0	15	1.00	ZZZ
93568	RUC REC	Inj, Pulm Angio	0	20	0	20	0.98	ZZZ
11046	Ref	Debride muscle facial add on	0	20	1	21	0.70	ZZZ

AMA/Specialty Society RVS Update Committee
Summary of Recommendations
Originated from the Five-Year Review Codes Reported Together Screen and CMS Request: PE Review

February and April 2010

Diagnostic Cardiac Catheterization

The RUC identified the cardiac catheterization services as potentially misvalued through its Codes Frequently Reported Together screen as combinations of these codes are reported together more than 95% of the time on the same date of service by the same physician. To address any potential duplication in either work or practice expense, the RUC recommended that the services be referred to the CPT Editorial Panel for development of code change proposals to condense code pairs into a single code and create new coding structure for reporting cardiac catheterization. The specialty submitted a code change proposal for the June 2009 CPT meeting, however, the Panel postponed review until October 2009 to provide the Panel with additional time to review. In October 2009, the CPT Editorial Panel approved the addition of 20 codes, introductory language and deletion of 19 codes to accurately report diagnostic cardiac catheterization and injection services where imaging supervision and intra-procedural injection(s) have been bundled into the cardiac catheterization services.

The RUC reviewed these services in families: Coronaries, Coronaries and Grafts, Non-Coronaries, Injection-Imaging Add-on Codes, Congenital Add-on Codes and Procedural Add-on Codes.

Coronaries:

93458 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed

The RUC reviewed the survey data from 108 cardiologists for the new bundled service, 93458. This code describes a service that was previously reported with coronary injection (93545 = 0.40 Work RVUs), S&I coronary injection (93556 = 0.83 Work RVUs), left heart catheterization (93510= 4.32 Work RVUs), left ventricular injection (93543=0.15 after 50% multiple procedure reduction) plus S&I for ventricular angiography (93555=0.81 Work RVUs), resulting in 6.51 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these

adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 93619 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia* (Work RVU=7.31). The RUC noted that the surveyed code has significantly less intra-service time as compared to the reference code, 45 minutes and 90 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment and technical skill as compared to the surveyed code. Although the survey median for this service was 8.03 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 6.51 work RVUs. **Therefore, the RUC recommends 6.51 Work RVUs for 93458.**

93454 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;

The RUC reviewed the survey data from 48 cardiologists for the new bundled service, 93454. This code describes a service that was previously reported with coronary angiography (93508=4.09 Work RVUs), coronary injection (93545=0.40 Work RVUs), plus S&I for coronary injection (93556=0.83 Work RVUs), resulting in 5.32 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 93619 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia* (Work RVU=7.31). The RUC noted that the surveyed code has significantly less intra-service time as compared to the reference code, 30 minutes and 90 minutes, respectively. Further, the RUC noted that the reference code requires more mental effort and judgment and technical skill as compared to the surveyed code. After reviewing the these comparisons the RUC agreed that the 25th percentile, 4.95 Work RVUs accurately reflects the work it requires to perform this service. This value represents a decrease in the current valuation of this service, 5.32 work RVUs. **Based on this information, the RUC recommends 4.95 Work RVUs for 93454.**

93456 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization

The RUC reviewed the survey data from 48 cardiologists for the new bundled service, 93456. This code describes a service that was previously reported with coronary angiography (93508=4.09 Work RVUs), coronary injection (93545=0.40 Work RVUs), S&I for coronary injection (93556=0.83) plus right heart catheterization (93501=1.51 Work RVU after the 50% multiple procedure reduction), resulting in 6.83 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 37187 *Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance* (Work RVU=8.03). The RUC noted that although the intensity/complexity measures for this service are similar, the reference code requires significantly more intra-service time as compared to the surveyed code, 85 minutes and 40 minutes, respectively. After reviewing these comparisons, the RUC agreed that the 25th percentile, 6.00 Work RVUs accurately reflects the work it requires to perform this service. This value reflects a decrease in the current valuation of this service, 6.83 work RVUs. **Based on this information, the RUC recommends 6.00 Work RVUs for 93456.**

93460 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed

The RUC reviewed the survey data from 48 cardiologists for the new bundled service, 93460. This code describes a service that was previously reported with coronary injection (93535=0.40 Work RVUs), S&I for coronary injection (93556=0.83 Work RVUs), left ventricular injection (93543=0.15 after 50% multiple procedures reduction), S&I for ventricular angiography (93555=0.81 Work RVUs) plus 93526=5.98 Work RVUs), resulting in 8.17 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 37184 *Primary percutaneous transluminal*

mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel (Work RVU=8.66). The RUC noted that although the intensity/complexity measures for this service are the same, the reference code requires significantly more intra-service time as compared to the surveyed code, 90 minutes and 50 minutes, respectively. After reviewing these comparisons, the RUC agreed that the 25th percentile, 7.88 Work RVUs, accurately reflects the work it requires to perform this service. This value represents a decrease in the current valuation of this service, 8.17 work RVUs. **Based on this information, the RUC recommends 7.88 Work RVUs for 93460.**

Coronaries and Grafts:

93455 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography

The RUC reviewed the survey data from 48 cardiologists for the new bundled service, 93455. This code describes a service that was previously reported with coronary angiography (93508=4.09 Work RVUs), coronary injection (93545=0.40 Work RVUs), S&I for coronary injection (93556=0.83 Work RVUs), cardiac catheterization injection arterial conduits (93539=0.40 Work RVUs) plus cardiac catheterization injection aortocoronary venous bypass grafts (93540=0.43 Work RVUs), resulting in 6.15 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 12 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment and additionally for this service the physician must review additional films as the patient had prior bypass grafts. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 93619 *Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia* (Work RVU=7.31). The RUC noted that the surveyed codes requires less intra-service time as compared to the reference code, 40 minutes and 90 minutes, respectively. Further, the RUC noted that the reference code requires has more psychological stress associated with it as compared to the surveyed code. Although the survey median for this service was 8.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 6.15 work RVUs. **Therefore, the RUC recommends 6.15 Work RVUs for 93455.**

93457 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization

The RUC reviewed the survey data from 38 cardiologists for the new bundled service, 93457. This code describes a service that was previously reported with coronary angiography (93508=4.09 Work RVUs), coronary injection (93545=0.40 Work RVUs), S&I for coronary injection (93556=0.83 Work RVUs), cardiac catheterization injection arterial conduits (93539=0.40 Work RVUs) plus cardiac catheterization injection aortocoronary venous bypass grafts (93540=0.43 Work RVUs) plus right heart catheterization (93501=1.51 after 50% multiple procedure reduction), resulting in 7.66 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 12 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Additionally for this service the physician must review additional films as the patient had prior bypass grafts. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 37184 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel* (Work RVU=8.66) The RUC noted that the reference code required more intra-service time in comparison to the surveyed code 90 minutes and 50 minutes, respectively. Further, the RUC acknowledged that the reference code required a higher urgency of medical decision making and had a higher risk of significant complications, morbidity and mortality as compared to the surveyed code. Although the surveyed 25th percentile for this service was 8.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 7.66 work RVUs. **Therefore, the RUC recommends 7.66 Work RVUs for 93457.**

93459 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

The RUC reviewed the survey data from 38 cardiologists for the new bundled service, 93459. This code describes a service that was previously reported with coronary injection (93545=0.40 Work RVUs), S&I coronary injection (93556=0.83 Work RVUs), left heart catheterization (93510=4.32 Work RVUs), left ventricular injection (93543=0.15 Work RVUs after 50% multiple procedure reduction), S&I for ventricular angiography (93555=0.81 Work RVUs), cardiac catheterization injection arterial conduits (93539=0.40 Work RVUs) plus cardiac catheterization injection aortocoronary venous bypass grafts (93540=0.43 Work RVUs), resulting in 7.34 Work RVUs. The

RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 12 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Additionally for this service the physician must review additional films as the patient had prior bypass grafts. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 37184 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel* (Work RVU=8.66) The RUC noted that the reference code required more intra-service time in comparison to the surveyed code 90 minutes and 60 minutes, respectively. Further, the RUC acknowledged that the reference code was a more intense service to perform as compared to the surveyed code. Although the surveyed 25th percentile for this service was 8.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 7.34 work RVUs. **Therefore, the RUC recommends 7.34 Work RVUs for 93459.**

93461 Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography

The RUC reviewed the survey data from 38 cardiologists for the new bundled service, 93461. This code describes a service that was previously reported with coronary injection (93545=0.40 Work RVUs), S&I coronary injection (93556=0.83 Work RVUs), left ventricular injection (93543=0.15 Work RVUs after 50% multiple procedure reduction), S&I for ventricular angiography (93555=0.81 Work RVUs), combined right and retrograde left heart catheterization (93526=5.98 Work RVUs), cardiac catheterization injection arterial conduits (93539=0.40 Work RVUs) plus cardiac catheterization injection aortocoronary venous bypass grafts (93540=0.43 Work RVUs), resulting in 9.00 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 12 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Additionally for this service the physician must review additional films as the patient had prior bypass grafts. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to reference code 93620 *Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple*

electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording (Work RVU=11.57). The RUC noted that the reference code has significantly more intra-service time as compared to the surveyed code, 120 minutes and 65 minutes, respectively. Further, the RUC acknowledged that the reference code requires more physical effort to perform and has more risk of significant complication, morbidity and mortality as compared to the surveyed code. Although the surveyed median for this service was 11.25 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 9.00 work RVUs. **Therefore, the RUC recommends 9.00 Work RVUs for 93461.**

Non-Coronaries:

93451 Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed

The RUC reviewed the survey data from 68 cardiologists for the new code, 93451. This code describes a service that was previously reported with right heart catheterization (93501=3.02 Work RVUs). The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to the reference code 93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes* (Work RVU=2.91). The RUC noted that the surveyed code had significantly more intra-service time as compared to the reference code 30 minutes and 15 minutes, respectively. The RUC noted that the surveyed code required more mental effort and judgment to perform in comparison to the reference code. Although the surveyed median for this service was 4.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 3.02 work RVUs. **Therefore, the RUC recommends 3.02 Work RVUs for 93451.**

93452 Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed

The RUC reviewed the survey data from 68 cardiologists for the new bundled service, 93452. This code describes a service that was previously reported with left heart catheterization (93510=4.32 Work RVUs), left ventricular injection (93543 =0.15 Work RVUs after 50% multiple procedure reduction) plus S&I for ventricular angiography (93555=0.81 Work RVUs), resulting in 5.28 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-

service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to the reference code 93624 *Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia* (Work RVU=4.80). The RUC noted that the reference code had more intra-service time as compared to the surveyed code, 68 minutes and 30 minutes, respectively. Further, the RUC agreed that the reference code was a more intense procedure to perform as compared to the surveyed code. Although the surveyed 25th percentile was 4.00 Work RVUs, the specialty society recommended and the RUC agreed that in order to maintain relativity to the other codes within this family, the work for 93452 should be crosswalked to 93510 (4.32 Work RVUs). **Therefore, the RUC recommends 4.32 Work RVUs for 93452.**

93453 Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed

The RUC reviewed the survey data from 68 cardiologists for the new bundled service, 93452. This code describes a service that was previously reported with combined right and retrograde left heart catheterization (93526=5.98 Work RVUs), left ventricular injection (93543 =0.15 Work RVUs after 50% multiple procedure reduction) plus S&I for ventricular angiography (93555=0.81 Work RVUs), resulting in 6.94 Work RVUs. The RUC agrees that the recommended service times are reflective of this service. The specialty society explained that they selected pre-service time package 2B Difficult Patient/Straightforward Procedure (with sedation) and added 7 minutes of pre-service evaluation time and 2 minutes of positioning time as these time modifications most accurately reflect the survey data. The specialty society explained and the RUC agreed that these adjustments were appropriate as the cardiologist is not only performing the cardiac catheterization but also is providing the moderate sedation as well as using imaging equipment. Further, the specialty society explained and the RUC agreed that there is additional time required for positioning as although the patient is supine, the physician must consider the sedation lines, and catheters, imaging equipment and contrast-injection equipment in relation to the patient. The RUC compared the surveyed code to the reference code 31600 *Tracheostomy, planned (separate procedure)*; (Work RVU=7.17). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 45 minutes and 40 minutes, respectively. Although the surveyed 25th percentile was 5.44 Work RVUs, the specialty society recommended and the RUC agreed that in order to maintain relativity to the other codes within this family, the work for 93453 should be crosswalked to 93526 (5.98 Work RVUs). **Therefore, the RUC recommends 5.98 Work RVUs for 93453.**

Injection – Imaging Add-on Codes

93566 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective right ventricular or right atrial angiography

The RUC reviewed the survey data from 57 cardiologists for new bundled service, 93566. This code represents a service that was previously reported with right ventricular injection (93542=0.15 Work RVUs after 50% multiple procedure reduction) and S&I for ventricular angiography (93555=0.81 Work RVUs), resulting in 0.96 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agrees that the modified service time accurately reflects the service. The RUC compared this service to reference code 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report* (Work RVU=0.75). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 20 minutes and 15 minutes, respectively. Further, the RUC agreed that the surveyed code is a more intense service to perform in comparison to the reference code. Although the surveyed median for this service was 2.00 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.96 work RVUs. **Therefore, the RUC recommends 0.96 Work RVUs for 93566.**

93567 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for supraaortic aortography

The RUC reviewed the survey data from 66 cardiologists for new bundled service, 93567. This code represents a service that was previously reported with aortography (93544=0.25 Work RVUs) and S&I coronary injection (93556=0.83 Work RVUs), resulting in 1.08 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agrees that the modified service time accurately reflects the service. The RUC compared this service to reference code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel* (Work RVU=1.80). The RUC noted that the surveyed code has less intra-service time as compared to the reference code, 15 minutes and 25 minutes, respectively. Further, the RUC agreed that the reference code is a more intense service to perform in comparison to the surveyed code. Although the surveyed 25th percentile for this service was 1.10 Work RVUs, the specialty society recommended and the RUC agreed that the current value for this service, 1.08 Work RVUs, creates a rank order anomaly with this service and 93566 and 93568. Therefore, the RUC directly crosswalked the value of this service to 99213 *Office or other outpatient visit for the evaluation and management of an established patient*, (Work RVU=0.97) as both of these services are similarly intense and both have 15 minutes of intra-service time. This recommended value also maintains rank order with 93566 and 93568. **The RUC recommends 0.97 Work RVUs for 93567.**

93568 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for pulmonary angiography

The RUC reviewed the survey data from 58 cardiologists for the new bundled service, 93568. This code represents a service that was previously reported with pulmonary angiography (93541=0.15 after 50% multiple procedure reduction) and S&I coronary injection (93556=0.83 Work RVUs), resulting in 0.98 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agrees that the modified service time accurately reflects the service. The RUC compared this service to reference code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel* (Work RVU=1.80). The RUC noted that the surveyed code has slightly less intra-service time as compared to the reference code, 20 minutes and 25 minutes, respectively. Further, the RUC agreed that the reference code requires the same amount of intensity to perform as the surveyed code. Although the surveyed 25th percentile for this service was 1.80 Work RVUs, the specialty society recommended and the RUC agreed that there was no compelling evidence to change the current value for this service, 0.98 work RVUs. **Therefore, the RUC recommends 0.98 Work RVUs for 93568.**

Congenital Add-On Codes:

The RUC expressed concern about the response rate of these three services. The specialty society explained that these are very low volume services and therefore it was difficult to get a robust survey response. The RUC acknowledged that this rationale was appropriate and reasonable.

93563 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization

The RUC reviewed the survey data for the new bundled service, 93563. This code represents a service that was previously reported with coronary injection (93545=0.40 Work RVUs) and S&I coronary injection (93556=0.83 Work RVUs), resulting in 1.23 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agrees that the modified service time accurately reflects the service. The specialty societies also explained that they had compelling evidence to support their recommendation that the current value for this service, via component coding, is incorrect. The specialty societies stated and the RUC agreed that there is evidence that the patient population has changed as the current typical patient has congenital heart disease which was not true of this service when originally reviewed.

The RUC compared this service to reference code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel* (Work RVU=1.80). The RUC noted that although the surveyed code has the same intra-service time as compared to the reference code, 25 minutes, the RUC agreed that the surveyed code is a more intense service to perform in comparison to the reference code. Further, the RUC compared the surveyed code to MPC code 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less* (Work RVU=2.19). The RUC noted that 13133 has more intra-service time as compared to the surveyed code, 30 minutes and 25 minutes respectively. **Based on these comparisons, the RUC recommends 2.00 Work RVUs, the survey median, for 93563.**

93564 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed

The RUC reviewed the survey data for the new bundled service, 93564. This code represents a service that was previously reported with coronary injection (93540=0.43 Work RVUs) and S&I coronary injection (93556=0.83 Work RVUs), resulting in 1.26 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agreed that the modified service time accurately reflects the service. The specialty societies also explained that they had compelling evidence to support their recommendation that the current value for this service, via component coding, is incorrect. The specialty societies stated and the RUC agreed that there is evidence that the patient population has changed as the current typical patient has congenital heart disease which was not true of this service when originally reviewed.

The RUC compared this service to the reference code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel* (Work RVU=1.80). The RUC noted that although the surveyed code has the same intra-service time as compared to the reference code, 25 minutes, the RUC agreed that the surveyed code is a more intense service to perform in comparison to the reference code. Further, the RUC compared the surveyed code to MPC code 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less* (Work RVU=2.19). The RUC noted that 13133 has more intra-service time as compared to the surveyed code, 30 minutes and 25 minutes respectively. Given these comparisons, the RUC agreed that 2.10 work RVUs, the survey median, accurately reflects the amount of work it requires to perform this service as well as maintain rank order between this service and 93563 and 93565. **The RUC recommends 2.10 Work RVUs for 93564.**

93565 Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective left ventricular or left atrial angiography

The RUC reviewed the survey data for the new bundled service, 93565. This code represents a service that was previously reported with left ventricular injection (93543=0.15 Work RVUs after 50% multiple procedure reduction) and S&I for ventricular angiography (93555=0.81 Work RVUs), resulting in 0.96 Work RVUs. The RUC had concerns about the recommended post-service time of 5 minutes. The specialty societies explained that this additional time was needed to review the additional images obtained. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes. The RUC agreed that the modified service time accurately reflects the service. The specialty societies also explained that they had compelling evidence to support their recommendation that the current value for this service, via component coding, is incorrect. The specialty societies stated and the RUC agreed that there is evidence that the patient population has changed as the current typical patient has congenital heart disease which was not true of this service when originally reviewed.

The RUC compared this service to the reference code 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel* (Work RVU=1.80). The RUC noted that although the surveyed code has less intra-service time as compared to the reference code, 20 minutes and 25 minutes, respectively, the RUC agreed that the surveyed code is a more intense service to perform in comparison to the reference code. Further, the RUC compared the surveyed code to MPC code 13133 *Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less* (Work RVU=2.19). The RUC noted that 13133 has more intra-service time as compared to the surveyed code, 30 minutes and 20 minutes respectively. Given these comparisons, the RUC agreed that 1.90 work RVUs, the survey median, accurately reflects the amount of work it requires to perform this service as well as maintain rank order between this service and 93563 and 93565. **The RUC recommends 1.90 Work RVUs for 93565.**

Procedural Add-on Codes:

These services represent new technology which were previously reported with unlisted services. Thus, these services do not require compelling evidence to justify their value. **Further, to ensure that the utilization estimates provided by the specialty are accurate, the RUC recommended that 93463, 93464, 93462 be added to the New Technology/Service List.**

93463 Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) and repeat hemodynamic measurements The RUC reviewed the survey data from 40 survey respondents for 93463 and had concerns about the recommended post-service time of 10 minutes. The specialty societies explained that this additional time was needed to review the cardiac output/hemodynamics/blood pressure prior, during and after the service performed. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ

global codes. Based on this decision, the RUC agreed that the descriptor for this service should be modified to clearly describe the service being performed. **The RUC recommends the following modified descriptor for 93463:**

Pharmacologic agent(s) administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessment of hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed and repeat hemodynamic measurements (List separately in addition to code for primary procedure)

The RUC compared this service to the reference code 93571 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel* (Work RVU=1.80). The RUC noted that 93571 has more intra-service time as compared to the surveyed code, 30 minutes and 20 minutes respectively. Further, the RUC noted that the surveyed code requires more mental effort and judgment than the reference code. Given these comparisons, the RUC agreed that 2.00 work RVUs, the survey's 25th percentile, accurately reflects the amount of work it requires to perform this service. **The RUC recommends 2.00 Work RVUs for 93463.**

93464 Physiologic exercise study (eg, bicycle or arm ergometry, or pharmacologic exercise) and repeat hemodynamic measurements

The RUC reviewed the survey data for 93464 and had concerns about the recommended post-service time of 10 minutes. The specialty societies explained that this additional time was needed to review the cardiac output/hemodynamics/blood pressure prior and after the service performed. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes.

The RUC compared the surveyed code to the reference code 93571 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel* (Work RVU=1.80). The RUC noted that the surveyed code has more intra-service time as compared to the reference code, 30 minutes and 20 minutes, respectively. However, the RUC noted that the reference code requires more technical skill, physical effort and causes more psychological stress as compared to the surveyed code. Given these comparisons, the RUC agreed that 1.80 work RVUs, the survey's 25th percentile, accurately reflects the amount of work it requires to perform this service as well as maintain rank order between this service and 93462 and 93463. **The RUC recommends 1.80 Work RVUs for 93464. In addition, The RUC recommends that this service be referred to the CPT Editorial Panel to remove "or pharmacologic exercise" be removed from the descriptor to clarify the difference between 93463 and 93464. Further, the RUC requested that the assessing hemodynamic measurements language be added to this descriptor as well resulting in the following modified language:**

Physiologic exercise study (eg, bicycle or arm ergometry, ~~or pharmacologic exercise~~) ~~and repeat hemodynamic measurements including assessment of hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed and repeat hemodynamic measurements~~ (List separately in addition to code for primary procedure)

93462 Left heart catheterization by transeptal puncture through intact septum or by transapical puncture

The RUC reviewed the survey data for 93462 and had concerns about the recommended pre-service time of 10 minutes. The specialty societies explained that this additional time was needed to obtain additional consent with the patient because of the severe risks to the patient and the equipment required this procedure must be set-up by the physician. The RUC agreed that this work was better represented in the intra-service time and makes the service time consistent with other ZZZ global codes.

The RUC agreed that the service should be cross-walked to 14302 *Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof* (Work RVU=3.73, ZZZ Global), which has the same intra-service time, 40 minutes, and requires the same amount of intensity to perform. This value is further supported by an additional reference code 35685 *Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit* (Work RVU=4.04, ZZZ Global), which has 5 more minutes of intra-service time in comparison to 93462. **The RUC recommends 3.73 Work RVU and 40 minutes of intra-service time for 93462.**

Moderate Sedation: The RUC after reviewing the survey data for all of the diagnostic cardiac catheterization services noted the moderate sedation was inherent. **Therefore, the RUC recommends that all of the diagnostic cardiac catheterization services be added to Appendix G in the CPT 2011 Book and each code be designated with a ©.**

Work Neutrality

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

Practice Expense

The RUC reviewed and accepted the practice expense inputs for 93451-93568 as approved by the PE Subcommittee.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p>Cardiac catheterization is a diagnostic medical procedure which includes introduction, positioning, and repositioning, <u>when necessary, of catheter(s) when necessary, within the vascular system, recording of intracardiac and/or intravascular pressure(s), and final evaluation and report of procedure.</u> There are two code families for cardiac catheterization: one for congenital heart disease and one for all other conditions. Anomalous coronary arteries, patent foramen ovale, mitral valve prolapse, and bicuspid aortic valve are to be reported with 93460-93464, 93566-93568.</p> <p><u>Right heart catheterization includes catheter placement in one or more right-sided cardiac chamber(s) or structures (the right atrium, right ventricle, pulmonary artery, pulmonary wedge), obtaining blood samples for measurement of blood gases, or dilution curves and cardiac output measurements (Fick or other method), when performed, with or without rest and exercise and/or studies) with or without electrode catheter placement, final evaluation and report of procedure.</u> Left heart catheterization involves catheter placement in a left-sided (systemic) cardiac chamber(s) (left ventricle or left atrium) and includes left ventricular injection(s) when performed. Do not report code 93503 in conjunction with other diagnostic cardiac catheterization codes. When right heart catheterization is performed in conjunction with other cardiac catheterization services, report 93453, 93456, 93457, 93460, or 93461. For placement of a flow directed catheter (eg, Swan-Ganz) performed for hemodynamic monitoring purposes not in conjunction with other catheterization services, use 93503. For placement of a flow directed catheter for monitoring purposes, use 93503. Right heart catheterization does not include right ventricular or right atrial angiography (93566). When left heart catheterization is performed using either transapical puncture of the left ventricle or transseptal puncture of an intact septum, report 93462 in conjunction with 93452, 93453, 93458-93461, 93651, and 93652. Catheter placement(s) in coronary artery(ies) involves selective engagement of the origins of the native coronary artery(ies) for the purpose of coronary angiography. Catheter placement(s) in bypass graft(s) (venous, internal mammary, free arterial graft[s]) involve selective engagement of the origins of the graft(s) for the purpose of bypass angiography. It is typically performed only in conjunction with coronary angiography of native vessels.</p> <p><u>The cardiac catheterization codes (93452-93461), other than those for congenital heart disease, include contrast injection(s), imaging supervision, interpretation, and report for imaging typically performed. Codes for left heart catheterization (93452, 93453, 93458-93461), other than those for congenital heart disease, include intraprocedural injection(s) for left ventricular/left atrial angiography, imaging supervision, and interpretation, when performed. Codes for coronary catheter placement(s) (93454-93461), other than those for congenital heart disease, include intraprocedural injection(s) for coronary angiography, imaging supervision, and interpretation. Codes for catheter placement(s) in bypass graft(s) (93455, 93457, 93459, 93461), other than those for congenital heart disease, include intraprocedural injection(s) for bypass graft angiography, imaging supervision, and interpretation. Do not report 93563-93565 in conjunction with 93452-93461.</u></p> <p>For cardiac catheterization for congenital cardiac anomalies, see 93530-93533. When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital anomalies, see 93563-93568.</p>				

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
<p><u>Cardiac catheterization (93451-93461) includes all roadmapping angiography in order to place the catheters, including any injections and imaging supervision, interpretation, and report. It does not include contrast injection(s) and imaging supervision, interpretation, and report for imaging that is separately identified by specific procedure code(s). For right ventricular or right atrial angiography performed in conjunction with cardiac catheterization for congenital or non-congenital heart disease (93451-93461, 93530-93533), use 93566. For aortography, use 93567. For pulmonary angiography, use 93568. For angiography of the non-coronary arteries and veins, performed as a distinct service, use appropriate codes from the 70000 series and the Vascular Injection Procedures section 30000 series. When selective injection procedures are performed without a preceding cardiac catheterization, these services should be reported using codes in the Vascular Injection Procedures section, 36011-36015 and 36215-36218.</u></p> <p><u>When cardiac catheterization is combined with pharmacologic agent administration with the specific purpose of repeating hemodynamic measurements to evaluate hemodynamic response, use 93463 in conjunction with 93451-93453 and 93456-93461. Do not report 93463 for intracoronary administration of pharmacologic agents during percutaneous coronary interventional procedures, during intracoronary assessment of coronary pressure, flow or resistance, or during intracoronary imaging procedures. Do not report 93463 in conjunction with 92975, 92977, 92980, 92982, or 92995.</u></p> <p><u>When cardiac catheterization is combined with exercise (eg, walking or arm or leg ergometry protocol) with the specific purpose of repeating hemodynamic measurements to evaluate hemodynamic response, report 93464 in conjunction with 93451-93453, 93456-93461, and 93530-93533.</u></p> <p><u>When coronary artery, arterial coronary conduit or venous bypass graft angiography is performed without concomitant left heart cardiac catheterization, use 93508. Injection procedures 93539, 93540, 93544, and 93545 represent separate identifiable services and may be reported in conjunction with one another in addition to 93508, as appropriate. To report imaging supervision, interpretation and report in conjunction with 93508, use 93556.</u></p> <p><u>Contrast injection to image the access site(s) for the specific purpose of placing a closure device is inherent to the catheterization procedure and not separately reportable. Closure device placement at the vascular access site is inherent to the catheterization procedure and not separately reportable.</u></p> <p>Modifier 51 should not be appended to 93503, 93539, 93540, 93544, 93556.</p>				
D ©93501		Right heart catheterization	000	N/A

CPT Code (•New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
Ø 93503		Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes	000	2.91 (No Change)
Ø 93505		Endomyocardial biopsy	000	4.37 (No Change)
D @93508		Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization	000	N/A
D @93510		Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous	000	N/A
D @93511		by cutdown	000	N/A
D @93514		Left heart catheterization by left ventricular puncture	000	N/A
D @93524		Combined transseptal and retrograde left heart catheterization	000	N/A
D @93526		Combined right heart catheterization and retrograde left heart catheterization	000	N/A
D @93527		Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)	000	N/A
D @93528		Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)	000	N/A
D @93529		Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization) (93501, 93508-93529 have been deleted. To report, see 93451-93461)	000	N/A
@93530		Right heart catheterization, for congenital cardiac anomalies	000	4.22 (No Change)

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
93531		Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	000	8.34 (No Change)
93532		Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	000	9.99 (No Change)
93533		Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies	000	6.69 (No Change)
☉ ● 93451	V1	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed (Do not report 93451 in conjunction with 93453, 93456, 93457, 93460, 93461)	000	3.02
☉ ● 93452	V2	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed (Do not report 93452 in conjunction with 93453, 93458-93461)	000	4.32
☉ ● 93453	V3	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed (Do not report 93453 in conjunction with 93451, 93452, 93456-93461)	000	5.98
☉ ● 93454	V4	Catheter placement in coronary artery(s) including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	000	4.95
☉ ● 93455	V5	with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	000	6.15
☉ ● 93456	V6	with right heart catheterization	000	6.00
☉ ● 93457	V7	with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft	000	7.66

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		angiography and right heart catheterization		
⊙ ● 93458	V8	with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	000	6.51
⊙ ● 93459	V9	with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	000	7.34
⊙ ● 93460	V10	with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	000	7.88
⊙ ● 93461	V11	with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	000	9.00
⊙+ ● 93462	V12	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture(List separately in addition to code for primary procedure) <u>(Use 93462 in conjunction with 93452, 93453, 93458-93461, 93651, 93652)</u>	ZZZ	3.73
+⊙ ● 93463	V13	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) and repeat hemodynamic measurements (List separately in addition to code for primary procedure) <u>(Use 93463 in conjunction with 93451-93453, 93456-93461, 93530-93533)</u> <u>(Do not report 93463 for pharmacologic agent administration in conjunction with coronary interventional procedure codes 92975, 92977, 92980, 92982, 92995)</u>	ZZZ	2.00
+⊙ ● 93464	V14	Physiologic exercise study (eg, bicycle or arm ergometry, or pharmacologic exercise) and repeat hemodynamic measurements (List separately in addition to code for primary procedure)	ZZZ	1.80

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(Use 93464 in conjunction with 93451-93453, 93456-93461, 93530-93533)		
<p>Injection Procedures</p> <p>All injection codes include radiological supervision, interpretation, and report. Cardiac catheterization codes (93452-93461), other than those for congenital heart disease, include contrast injection(s) for imaging typically performed during these procedures (see Cardiac Catheterization above). Do not report 93563-93565 in conjunction with 93452-93461. When injection procedures for right ventricular, right atrial, aortic, or pulmonary angiography are performed in conjunction with cardiac catheterization, these services are reported separately (93566-93568). When right ventricular or right atrial angiography is performed at the time of heart catheterization, use 93566 with the appropriate catheterization code (93451, 93453, 93456, 93457, 93460, or 93461). Use 93567 when supra-avalvular ascending aortography is performed at the time of heart catheterization. Use 93568 with the appropriate right heart catheterization code when pulmonary angiography is performed. Separately reported injection procedures do not include introduction of catheters but do include repositioning of catheters when necessary and use of automatic power injectors, when performed.</p> <p><u>When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital cardiac anomalies (93530-93533), see 93563-93568. Injection procedure codes 93563-93568 include imaging supervision, interpretation, and report.</u></p> <p>Injection procedures 93539-93545-93563-93568 represent separate identifiable services and may be coded in conjunction with one another when appropriate. The technical details of angiography, supervision of filming and processing, interpretation, and report are not included. To report radiological supervision, interpretation, and report for 93542 or 93543, use 93555. To report radiological supervision, interpretation, and report for 93539, 93540, 93541, 93544, or 93545, use 93556. Modifier 51 should not be appended to 93539, 93540, 93544-93556.</p>				
D @Ø 93539		Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass	XXX	N/A
D @Ø 93540		for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries	XXX	N/A
D @93541		for pulmonary angiography	XXX	N/A
D @93542		for selective right ventricular or right atrial angiography	XXX	N/A

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
D ◎93543		for selective left ventricular or left atrial angiography	XXX	N/A
D ◎∅ 93544		for aortography	XXX	N/A
D ◎∅ 93545		for selective coronary angiography (injection of radiopaque material may be by hand) <u>(93539-93545 have been deleted. To report, see 93451-93461, 93563-93568)</u>	XXX	N/A
D ∅93555		Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	XXX	N/A
D ◎∅ 93556		pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass) <u>(93555, 93556 have been deleted. See introductory guidelines for Cardiac Catheterization and Injection Procedures)</u>	XXX	N/A
◎+ ● 93563	V15	Injection procedure during cardiac catheterization including image supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)	ZZZ	2.00
◎+ ● 93564	V16	for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)	ZZZ	2.10
◎+ ● 93565	V17	for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)	ZZZ	1.90

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
		(Do not report 93563-93565 in conjunction with 93452-93461) (Use 93563-93565 in conjunction with 93530-93533)		
⊕+ ● 93566	V18	for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)	ZZZ	0.96
⊕+ ● 93567	V19	for supraaortic arch angiography (List separately in addition to code for primary procedure)	ZZZ	0.97
⊕+ ● 93568	V20	for pulmonary angiography (List separately in addition to code for primary procedure) (Use 93566-93568 in conjunction with 93530-93533, 93451-93461)	ZZZ	0.98



May 26, 2011

Jonathan Blum
Deputy Administrator and Director
Center for Medicare
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: HCPAC Recommendations

Dear Mr. Blum:

It is with pleasure that we submit to the Centers for Medicare and Medicaid Services (CMS), on behalf of the RUC Health Care Professionals Advisory Committee (HCPAC) Review Board, work relative value and direct practice expense inputs for CPT 2012.

These work relative value recommendations address New codes:

- Multi-Layer Compression System (29582, 29583 and 29584)

The RUC HCPAC also submits work relative value recommendations for CMS Request codes:

- Evaluation for Prescription of Non-Speech Generating-Augmentive and Alternative Communication Device (92605 and 92618)
- Otoacoustic Emissions Measurement (92558, 92587 and 92588)

The RUC HCPAC Review Board looks forward to continued CMS representation at our meetings and your effort to ensure a fair review of the enclosed recommendations. If you have any questions please contact AMA staff, Susan Clark, at (202) 789-7495 or via e-mail at Susan.Clark@ama-assn.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Arthur R. Traugott".

Arthur R. Traugott, MD

A handwritten signature in black ink, appearing to read "Lloyd S. Smith, DPM".

Lloyd S. Smith, DPM

cc: Edith Hambrick, MD
Marc Hartstein
Ryan Howe
Ken Simon, MD
Elizabeth Truong
HCPAC Participants

CPT 2012 HCPAC Recommendations

CPT	Global Period	Coding Change	CPT Meeting Date	Main Tab	Issue	Tracking Number	RUC Meeting Date	RUC Agenda Tab	SS to Survey	SS Recommendation	RUC Recommendation	Same RVU as last year?	Comments
29582	000	N	Jun10	07	Multi-Layer Compression System	A2	HCPAC	04	SVS, APTA, APMA	0.35	0.35		
29583	000	N	Jun10	07	Multi-Layer Compression System	A3	HCPAC	04	SVS, APTA, APMA	0.25	0.25		
29584	000	N	Jun10	07	Multi-Layer Compression System	A4	HCPAC	04	SVS, APTA, APMA	0.35	0.35		
92558	XXX	N	Feb11	60	Otoacoustic Emissions Measurement	DD1	HCPAC	35	ASHA	0.25	0.17		Relativity Assessment Workgroup
92587	XXX	R	Feb11	60	Otoacoustic Emissions Measurement	DD2	HCPAC	35	ASHA	0.55	0.45		Relativity Assessment Workgroup
92588	XXX	R	Feb11	60	Otoacoustic Emissions Measurement	DD3	HCPAC	35	ASHA	0.81	0.60		Relativity Assessment Workgroup
92605	XXX	R	Feb11	58	Evaluation for Prescription of Non-Speech Generating-Augmentive and Alternative Communication Device	EE1	HCPAC	35	ASHA	1.75	1.75		Relativity Assessment Workgroup
92618	ZZZ	N	Feb11	58	Evaluation for Prescription of Non-Speech Generating-Augmentive and Alternative Communication Device	EE2	HCPAC	35	ASHA	0.65	0.65		Relativity Assessment Workgroup

Health Care Professionals Advisory Committee (HCPAC) Review Board
Summary of Recommendations

October 2010

Multi-Layer Compression System

In June 2010, the CPT Editorial Panel created three new codes to describe the application of multi-layer compression to the upper and lower extremities, not just below the knee. Multi-layer compression systems are used to treat edema for a variety of indications, not just venous leg ulcers.

29582

The HCPAC reviewed CPT code 29582 *Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed*. Due to the low survey response rate and low experience with the service, the HCPAC agreed with the specialty society that the survey data was not reflective of the service. The specialty society, using an expert panel, developed an appropriate service time for the surveyed code and developed the recommended work RVU of 0.35 by crosswalking 29582 to reference code 97124 *Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)* (work RVU = 0.35 and intra-service time = 15 minutes). The HCPAC noted that CPT code 29582 has 4 minutes of pre-service time, 12 minutes intra-service time and 2 minutes immediate post-service time. The specialty society explained that the pre-service time is appropriate compared to reference service code 97124, because the reference code is a time based code with the assumption that it would be billed multiple times in the same session whereas the surveyed code would be billed once per session. The specialty society indicated that because these services require the same total service time (18 minutes) and intensity to perform they should be valued the same. The HCPAC agreed with the specialty society recommendations. The HCPAC agreed that code 29582 is less intense and complex than code 29581 *Application of multi-layer venous wound compression system, below knee* (work RVU = 0.60), which is intended predominantly for venous ulcer therapy and includes ulcer related care in addition to compression.

The HCPAC recommends a work RVU of 0.35 for 29582.

29583

The HCPAC reviewed CPT code 29583 *Application of multi-layer compression system upper arm and forearm*. Due to the low survey response rate and low experience with the service, the HCPAC agreed with the specialty society that the survey data was not reflective of the service. The specialty society, using an expert panel, developed an appropriate service time for the surveyed code and developed a recommended work RVU of 0.25 by crosswalking 29583 to reference code 97762 *Checkout for orthotic/prosthetic use, established patient, each 15 minutes* (work RVU = 0.25 and intra-service time = 14 minutes). The HCPAC noted that code 29583 requires less work than 29582 and 29584 due to the smaller amount of wrapping involved. The HCPAC noted that CPT code 29583 has 2 additional minutes of pre-service time compared to the reference service, code 97762. The specialty society explained that this additional 2 minutes was appropriate because the reference code is a time based code with the

assumption that it would be billed multiple times in the same session whereas the surveyed code would be billed once per session. The specialty society indicated that because the surveyed code and the reference code require similar total service time (16 minutes and 18 minutes, respectively) and intensity to perform they should be valued the same. Further, this recommended value maintains rank order within this family of codes. The HCPAC agreed with the specialty society recommendations. **The HCPAC recommends a work RVU of 0.25 for 29583.**

29584

The HCPAC reviewed CPT code 29584 *Application of multi-layer compression system; upper arm, forearm, hand and fingers*. Due to the low survey response rate and low experience with the service, the HCPAC agreed with the specialty society that the survey data was not reflective of the service. The specialty society, using an expert panel, developed an appropriate service time for the surveyed code and developed a recommended work RVU of 0.35 by crosswalking 29584 to reference code 97124 *Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)* (work RVU = 0.35 and intra-service time = 15 minutes). The HCPAC noted that CPT code 29584 has 4 minutes of pre-service time, 12 minutes intra-service time and 2 minutes immediate post-service time. The specialty society explained that the pre-service time is appropriate compared to reference service code 97124, because the reference code is a time based code with the assumption that it would be billed multiple times in the same session whereas the surveyed code would be billed once per session. The specialty society indicated that because these services require the same total service time (18 minutes) and intensity to perform they should be valued the same. Further, this recommended value maintains rank order within this family of codes. The HCPAC agreed with the specialty society recommendations. **The HCPAC recommends a work RVU of 0.35 for 29584.**

PLI Crosswalks:

The specialty society proposed and the HCPAC recommends that the PLI crosswalk for 29582 and 29584 is 97124 *Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)*. The specialty society proposed and the HCPAC recommends that the PLI crosswalk for 29583 is 97762 *Checkout for orthotic/prosthetic use, established patient, each 15 minutes*.

New Technology/Service List:

As these services represent new technology, the HCPAC recommends that these services be added to the New Technology/Service List for future review.

CPT Referral:

The specialty society proposed and the HCPAC recommends that these services be referred back to the CPT Editorial Panel for the inclusion of a parenthetical stating that these services should not be reported with the following services 97140 *Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes*, 36475 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated* and 36478 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated* as these services already allow for the use of compression wrapping. In October 2010, the CPT Editorial Panel added this parenthetical.

Practice Expense: The RUC reviewed the direct practice expense inputs recommendation for the facility and non-facility settings for codes 29582, 29583, and 29584, and made minor edits to reflect the typical patient scenario.

CPT Code (●New)	Track- ing Number	CPT Descriptor	Global Period	Work RVU Recommendation
29540		Strapping; ankle and/or foot (Do not report 29540 in conjunction with 29581, <u>29582</u>)	000	0.51 (No Change)
29580		Unna boot (Do not report 29580 in conjunction with 29581, <u>29582</u>)	000	0.55 (No Change)
▲29581	A1	Application of multi-layer venous wound -compression system, below knee ; <u>leg (below knee), including ankle and foot</u> (Do not report 29581 in conjunction with 29540, 29580, <u>29582</u> , 36475, 36478, 97140)	000	0.60 (No Change See RUC Recommendation)
●29582	A2	thigh and leg, including ankle and foot, when performed (Do not report 29582 in conjunction with 29540, 29580, 29581, 36475, 36478, 97140)	000	0.35 (HCPAC Recommendation)
●29583	A3	upper arm and forearm (Do not report 29583 in conjunction with 29584, 97140)	000	0.25 (HCPAC Recommendation)
●29584	A4	upper arm, forearm, hand, and fingers (Do not report 29584 in conjunction with 29583)	000	0.35 (HCPAC Recommendation)

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

CPT Code: 29582 Tracking Number A2 Specialty Society Recommended RVU: **0.35**
Global Period: 000 RUC Recommended RVU: **0.35**

CPT Descriptor: Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed (Do not report 29582 in conjunction with 29540, 29580, 29581, 36475, 36478, 97140)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 43-year-old female with a long history of venous insufficiency due to severe venous incompetence with reflux of the truncal and greater saphenous veins. The patient is obese and lives alone. Post operative high compression is required for 1-2 weeks and is usually provided by wearing a class II compression stocking. Therapeutic, full leg compression is required to reduce the potential risk of venous thromboembolism, prevent refilling of the ablated veins, and to reduce postoperative bruising and tenderness. During pre-op education, the surgeon has noticed that the patient has mobility limitations due to her obesity and has recommended the use of post-op multi-layer compression system rather than high compression stockings.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 5%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: An abbreviated history is obtained. Skin integrity, cardiopulmonary status, and peripheral vascular status are assessed. Treatment options are reviewed and communication occurs with the patient (and/or the patient's family) to explain the procedure, including a discussion of possible risks and complications.

Description of Intra-Service Work: With the foot in a 90 degree dorsiflexed position, the foot and ankle were bandaged, and the process continued up the leg, covering the skin with no gaps, to the groin. A figure of eight wrapping technique was used around the knee. An additional layer was applied with a 50% overlap and full stretch from the foot to the groin

Description of Post-Service Work: Instructions are provided for care, complications, and activity. Progress note and any correspondence with referring physicians are completed.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2010				
Presenter(s):	Richard Rausch, PT				
Specialty(s):	American Physical Therapy Association				
CPT Code:	29582				
Sample Size:	122	Resp N:	19	Response: 15.5 %	
Sample Type:	Convenience Additional Sample Information:				
	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	10.00	75.00	950.00
Survey RVW:	0.30	0.55	0.60	0.72	0.83
Pre-Service Evaluation Time:			15.00		
Pre-Service Positioning Time:			8.00		
Pre-Service Scrub, Dress, Wait Time:			5.00		
Intra-Service Time:	8.00	15.00	20.00	32.50	60.00
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		
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

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (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:	29582	Recommended Physician Work RVU: 0.35		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		4.00	7.00	-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:		12.00		
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	
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

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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
29580	000	0.55	RUC Time

CPT Descriptor Strapping, unna boot**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97140	XXX	0.43	RUC Time	12,400,468
<u>CPT Descriptor 1</u> Therapeutic procedure, one or more areas, each 15 minutes; manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99211	XXX	0.18	RUC Time	8,948,162

CPT Descriptor 2 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.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 84.2 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 29582	<u>Key Reference CPT Code:</u> 29580	<u>Source of Time</u> RUC Time
Median Pre-Service Time	4.00	8.00	
Median Intra-Service Time	12.00	12.00	
Median Immediate Post-service Time	2.00	7.00	
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 Total Time	18.00	27.00	
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	3.56
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The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.19	3.75
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Urgency of medical decision making	3.25	2.88
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.44	3.88
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Physical effort required	4.00	3.56
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Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.63	3.19
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Outcome depends on the skill and judgment of physician	4.38	3.81
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Estimated risk of malpractice suit with poor outcome	3.38	3.13
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INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.31	3.06
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Intra-Service intensity/complexity	4.31	3.63
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Post-Service intensity/complexity	3.06	2.88
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Additional Rationale and Comments

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

The American Physical Therapy Association convened an expert panel, familiar with the RUC process to review the results of the surveys for multi-layer compression systems (tracking numbers A2, A3, and A4). The expert panel was unable to support the median values that were obtained by the survey. Further, the expert panel was unable to support the 25th percentile values.

To prepare an appropriate recommendation, the expert panel further reviewed the available data and agreed that the reference code for the proposed codes was appropriate. This reference code, 29580 (Strapping, unna boot), has a total pre service time of 8 minutes, and intra service time of 12 minutes and a post service time of 7 minutes. The panel used these values to determine appropriate times for the multi-layer compression system codes. The resulting times are summarized in this table:

	29580 Unna Boot	29582 (A2) Leg and Thigh	29583 (A3) Arm	29584 (A4) Arm and Hand
Total Pre service	8 minutes	4	4	4
Intra service	12	12	10	12
Post service	7	2	2	2
Total	27	18	16	18

Having thus established appropriate times for the delivery of the services being valued, the expert panel then reviewed codes with which they were familiar that contained similar service times. For both 29582 and 29584, the expert panel felt that these codes would correspond appropriately to the value assigned to 97124, Therapeutic procedure, massage, each 15 minutes. This code has a Pre service time of 2 minutes, an intra service time of 14 minutes, and a post service time of 2 minutes. The work value for this code is 0.35 and the expert panel believes that this is an appropriate work value for the 29582 and 29584 codes.

For the 29583 code, the expert panel did not believe that this service should have a work value as high as the 29582 and 29584 codes due to the amount of wrapping that is involved. Consequently, after reviewing codes that contained similar service times, the expert panel concluded that 97762, Orthotic/Prosthetic Checkout, each 15 minutes, would be an appropriate comparison. This service has a Pre service time of 2 minutes, an intra service time of 14 minutes, and a post service time of 2 minutes. The work relative value is 0.25 and thus this is the recommendation of the expert panel regarding this service.

The expert panel did consider that the multi-layer compression service codes are classified as 000 codes while the comparison service codes have an XXX global period. In light of the service times all being approximately 15 minutes, the expert panel felt that the use of the codes was acceptable.

Additionally, the expert panel recommends that these service codes be referred back to the CPT Editorial Panel for the inclusion of an editorial comment that the code should not be reported with the following services which already allow for the use of compression wrapping: 97140 (Manual Therapy), and endovenous ablation therapy, codes 36475 and 36478.

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) Not reported

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 APTA

How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 1300000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. CPT Application

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 100,000 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Of 1.7 million units sold (CPT application), perhaps half will involve two wraps, so this results in 1.3 million services, a third of which will be Medicare (400,000). Given four codes in the family, one fourth of 400,00 is 100,000.

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? Yes

Professional Liability Insurance Information (PLI)

Does the reference CPT code selected for physician work serve as a reasonable reference for PLI crosswalk? (ie. similar work RVU, and specialty) No

If no, please select another crosswalk and provide a brief rationale. 29540

Indicate what risk factor the new/revised code should be assigned to determine PLI relative value. Non-Surgical

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

CPT Code:29583 Tracking Number A3 Specialty Society Recommended RVU: **0.25**
Global Period: 000 RUC Recommended RVU: **0.25**

CPT Descriptor: Application of multi-layer compression system; upper arm and forearm (Do not report 29583 in conjunction with 29584, 97140)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 45-year-old woman 9 months status post right mastectomy, radiation and chemotherapy. She presents to her oncologist with heaviness, tightness and swelling of her right arm and reports that her arm has been getting progressively uncomfortable, which is beginning to interfere with her responsibilities at work. On examination, the right hand is swollen, the arm tissue is firm with 3+ pitting, and the circumference is 5 cm larger than the left arm. Range of motion is limited. Diagnosis of moderate (Grade 2) edema is made and the patient is referred to the Physical Therapy Lymphedema Program for application of multi-layer compression system.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 5%

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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: An abbreviated history is obtained. Skin integrity, cardiopulmonary status, and peripheral vascular status are assessed. Treatment options are reviewed and communication occurs with the patient (and/or the patient's family) to explain the procedure, including a discussion of possible risks and complications.

Description of Intra-Service Work: The arm was positioned with the elbow in slight flexion (135 degrees) and the fingers spread wide, with the hand position palm down. The first bandage layer was applied from the palm to the top of the arm. A figure eight technique was used at the elbow. An additional layer was applied with 50% overlap and full stretch from the palm to the top of the arm.

Description of Post-Service Work: Instructions are provided for care, complications, and activity. Progress note and any correspondence with referring physicians are completed

SURVEY DATA

RUC Meeting Date (mm/yyyy)		09/2010			
Presenter(s):	Richard Rausch, PT				
Specialty(s):	American Physical Therapy Association				
CPT Code:	29583				
Sample Size:	121	Resp N:	19	Response: 15.7 %	
Sample Type:	Convenience Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	0.00	0.00	8.50
Survey RVW:		0.33	0.50	0.55	0.69
Pre-Service Evaluation Time:				15.00	
Pre-Service Positioning Time:				5.00	
Pre-Service Scrub, Dress, Wait Time:				5.00	
Intra-Service Time:		5.00	20.00	30.00	45.00
Immediate Post Service-Time:		15.00			
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		
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

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (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:	29583	Recommended Physician Work RVU: 0.25		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time
Pre-Service Evaluation Time:		4.00	7.00	-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:		10.00		
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	
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

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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
29580	000	0.55	RUC Time

CPT Descriptor Strapping; Unna boot**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97140	XXX	0.43	RUC Time	12,400,468
<u>CPT Descriptor 1</u> Therapeutic procedure, one or more areas, each 15 minutes; manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes				

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99211	XXX	0.18	RUC Time	8,948,162

CPT Descriptor 2 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

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 11 % of respondents: 0.0 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 29583	<u>Key Reference CPT Code:</u> 29580	<u>Source of Time</u> RUC Time
Median Pre-Service Time	4.00	8.00	
Median Intra-Service Time	10.00	12.00	
Median Immediate Post-service Time	2.00	7.00	
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 Total Time	16.00	27.00	
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	4.00	3.55
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.91	3.73
--	------	------

Urgency of medical decision making	3.00	3.09
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Technical Skill/Physical Effort (Mean)

Technical skill required	4.55	3.73
--------------------------	------	------

Physical effort required	4.00	3.55
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.73	3.18
---	------	------

Outcome depends on the skill and judgment of physician	4.45	3.73
--	------	------

Estimated risk of malpractice suit with poor outcome	3.64	3.27
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.55	3.27
----------------------------------	------	------

Intra-Service intensity/complexity	4.55	3.91
------------------------------------	------	------

Post-Service intensity/complexity	3.00	2.91
-----------------------------------	------	------

Additional Rationale and Comments

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

The American Physical Therapy Association convened an expert panel, familiar with the RUC process to review the results of the surveys for multi-layer compression systems (tracking numbers A2, A3, and A4). The expert panel was unable to support the median values that were obtained by the survey. Further, the expert panel was unable to support the 25th percentile values.

To prepare an appropriate recommendation, the expert panel further reviewed the available data and agreed that the reference code for the proposed codes was appropriate. This reference code, 29580 (Strapping, unna boot), has a total pre service time of 8 minutes, and intra service time of 12 minutes and a post service time of 7 minutes. The panel used these values to determine appropriate times for the multi-layer compression system codes. The resulting times are summarized in this table:

	29580 Unna Boot	29582 (A2) Leg and Thigh	29583 (A3) Arm	29584 (A4) Arm and Hand
Total Pre service	8 minutes	4	4	4
Intra service	12	12	10	12
Post service	7	2	2	2
Total	27	18	16	18

Having thus established appropriate times for the delivery of the services being valued, the expert panel then reviewed codes with which they were familiar that contained similar service times. For both 29582 and 29584, the expert panel felt that these codes would correspond appropriately to the value assigned to 97124, Therapeutic procedure, massage, each 15 minutes. This code has a Pre service time of 2 minutes, an intra service time of 14 minutes, and a post service time of 2 minutes. The work value for this code is 0.35 and the expert panel believes that this is an appropriate work value for the 29582 and 29584 codes.

For the 29583 code, the expert panel did not believe that this service should have a work value as high as the 29582 and 29584 codes due to the amount of wrapping that is involved. Consequently, after reviewing codes that contained similar service times, the expert panel concluded that 97762, Orthotic/Prosthetic Checkout, each 15 minutes, would be an appropriate comparison. This service has a Pre service time of 2 minutes, an intra service time of 14 minutes, and a post service time of 2 minutes. The work relative value is 0.25 and thus this is the recommendation of the expert panel regarding this service.

The expert panel did consider that the multi-layer compression service codes are classified as 000 codes while the comparison service codes have an XXX global period. In light of the service times all being approximately 15 minutes, the expert panel felt that the use of the codes was acceptable.

Additionally, the expert panel recommends that these service codes be referred back to the CPT Editorial Panel for the inclusion of an editorial comment that the code should not be reported with the following services which already allow for the use of compression wrapping: 97140 (Manual Therapy), and endovenous ablation therapy, codes 36475 and 36478.

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) Not reported

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 APTA How often? Rarely

Specialty How often?

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

CPT Code: 29584 Tracking Number A4 Specialty Society Recommended RVU: **0.35**
Global Period: 000 RUC Recommended RVU: **0.35**

CPT Descriptor: Application of multi-layer compression system; upper arm, forearm, hand, and fingers (Do not report 29584 in conjunction with 29583)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: The patient is a 52-year-old woman 12 months status post bi-lateral mastectomy, radiation and chemotherapy. She presents to her oncologist with heaviness, tightness and swelling of her left arm, hand and fingers and reports that the swelling has been getting progressively uncomfortable which is beginning to interfere with her responsibilities at work. On examination, the left hand and fingers are swollen, the arm tissue is firm with 3+ pitting, and the circumference is 5 cm larger than the right arm. Range of motion is limited. Diagnosis of moderate (Grade 2) edema is made and the patient is referred to the Physical Therapy Lymphedema Program for application of multi-layer compression system.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)?

Is moderate sedation inherent in your reference code (Hospital/ASC setting)?

Description of Pre-Service Work: An abbreviated history is obtained. Skin integrity, cardiopulmonary status, and peripheral vascular status are assessed. Treatment options are reviewed and communication occurs with the patient (and/or the patient's family) to explain the procedure, including a discussion of possible risks and complications

Description of Intra-Service Work: The left arm was positioned with the elbow in slight flexion (135 degrees) and the fingers spread wide, with the hand position palm down. The fingers, hand and arm are bandaged with a tubular gauze sleeve; soft roll gauze was used for the fingers, followed by padding materials. The fingers were all individually wrapped. After securing the gauze and padding materials, the first compression bandage layer was applied to the fingers, palm and up to the top of the arm. A figure-of-eight technique was used at the elbow. An additional layer was applied with 50% overlap and full stretch from the palm to the top of the arm.

Description of Post-Service Work: Instructions are provided for care, complications, and activity. Progress note and any correspondence with referring physicians are completed

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2010					
Presenter(s):	Richard Rausch, PT					
Specialty(s):	American Physical Therapy Association					
CPT Code:	29584					
Sample Size:	123	Resp N:	14	Response: 11.3 %		
Sample Type:	Convenience Additional Sample Information:					
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	0.00	0.50	5.00	950.00
Survey RVW:		0.33	0.55	0.65	0.73	1.10
Pre-Service Evaluation Time:				15.00		
Pre-Service Positioning Time:				5.00		
Pre-Service Scrub, Dress, Wait Time:				5.00		
Intra-Service Time:		15.00	25.00	30.00	30.00	60.00
Immediate Post Service-Time:		12.50				
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			
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	

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (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:	29584	Recommended Physician Work RVU: 0.35			
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to Pre-Service Time	
Pre-Service Evaluation Time:		4.00	7.00	-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:		12.00			
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		
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

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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
29580	000	0.55	RUC Time

CPT Descriptor Strapping; Unna boot**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97140	XXX	0.43	RUC Time	12,400,468

CPT Descriptor 1 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99211	XXX	0.18	RUC Time	8,948,162

CPT Descriptor 2

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 10 % of respondents: 71.4 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 29584	<u>Key Reference CPT Code:</u> 29580	<u>Source of Time</u> RUC Time
Median Pre-Service Time	4.00	8.00	
Median Intra-Service Time	12.00	12.00	
Median Immediate Post-service Time	2.00	7.00	
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 Total Time	18.00	27.00	
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	3.30
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.80	3.70
--	------	------

Urgency of medical decision making	2.80	2.90
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	4.60	4.20
--------------------------	------	------

Physical effort required	4.40	3.60
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	3.60	3.30
---	------	------

Outcome depends on the skill and judgment of physician	4.30	3.90
--	------	------

Estimated risk of malpractice suit with poor outcome	3.40	3.30
--	------	------

INTENSITY/COMPLEXITY MEASURES

CPT Code **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	3.00	3.00
----------------------------------	------	------

Intra-Service intensity/complexity	4.50	3.90
------------------------------------	------	------

Post-Service intensity/complexity	2.90	2.70
-----------------------------------	------	------

Additional Rationale and Comments

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

The American Physical Therapy Association convened an expert panel, familiar with the RUC process to review the results of the surveys for multi-layer compression systems (tracking numbers 29852, 29853, and 29854). The expert panel was unable to support the median values that were obtained by the survey. Further, the expert panel was unable to support the 25th percentile values.

To prepare an appropriate recommendation, the expert panel further reviewed the available data and agreed that the reference code for the proposed codes was appropriate. This reference code, 29580 (Strapping, unna boot), has a total pre service time of 8 minutes, and intra service time of 12 minutes and a post service time of 7 minutes. The panel used these values to determine appropriate times for the multi-layer compression system codes. The resulting times are summarized in this table:

	29580 Unna Boot	29582 (A2) Leg and Thigh	29583 (A3) Arm	29584 (A4) Arm and Hand
Total Pre service	8 minutes	4	4	4
Intra service	12	12	10	12
Post service	7	2	2	2
Total	27	18	16	18

Having thus established appropriate times for the delivery of the services being valued, the expert panel then reviewed codes with which they were familiar that contained similar service times. For both 29582 and 29584, the expert panel felt that these codes would correspond appropriately to the value assigned to 97124, Therapeutic procedure, massage, each 15 minutes. This code has a Pre service time of 2 minutes, an intra service time of 14 minutes, and a post service time of 2 minutes. The work value for this code is 0.35 and the expert panel believes that this is an appropriate work value for the 29582 and 29584 codes.

For the 29583 code, the expert panel did not believe that this service should have a work value as high as the 29582 and 29584 codes due to the amount of wrapping that is involved. Consequently, after reviewing codes that contained similar service times, the expert panel concluded that 97762, Orthotic/Prosthetic Checkout, each 15 minutes, would be an appropriate comparison. This service has a Pre service time of 2 minutes, an intra service time of 14 minutes, and a post service time of 2 minutes. The work relative value is 0.25 and thus this is the recommendation of the expert panel regarding this service.

The expert panel did consider that the multi-layer compression service codes are classified as 000 codes while the comparison service codes have an XXX global period. In light of the service times all being approximately 15 minutes, the expert panel felt that the use of the codes was acceptable.

Additionally, the expert panel recommends that these service codes be referred back to the CPT Editorial Panel for the inclusion of an editorial comment that the code should not be reported with the following services which already allow for the use of compression wrapping: 97140 (Manual Therapy), and endovenous ablation therapy, codes 36475 and 36478.

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) Not reported

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 APTA How often? Rarely

Specialty How often?

	1	2	3	4	5	6	7
1	Multi Layer Compression Wrap, Upper arm and forearm						
2	29583						
3		Total Survey (n=19)		Zero Performance (n=10)		Experienced (n=9)	
4							
5	Time (median)						
6	Pre Service						
7	Eval		15		12.5		15
8	Position		5		5		5
9	Scrub, Dress		5		5		5
10	Intra Service						
11	Post Service						
12							
13	Survey RVW						
14	Low		0.33		0.45		0.33
15	25th pctl		0.50		0.47		0.65
16	Median		0.55		0.55		0.68
17	75th pctl		0.69		0.55		0.75
18	High		2.00		0.83		2.00

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

CPT Long Descriptor: 29582 Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed (Do not report 29582 in conjunction with 29540, 29580, 29581)

Global Period: 000_____

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

APTA's Practice Expense Advisory Group consists of physical therapists who are familiar with the delivery of inpatient and outpatient physical therapy services and who have some experience with the RUC and practice expense process. In the case of services delivered by specialty/niche providers, additional physical therapists will be consulted to obtain clinical input. The Advisory Group met by phone on two occasions to develop and refine the practice expense inputs for the multi-layer compression system family of codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

The patient is met and gowned for the procedure; vital signs and other measurements (eg, circumferential measurements) are obtained and consent is obtained. The room is prepared for the patient and the patient is positioned for the procedure. A physical therapist assistant assists the therapist during the service, helping with the patient's extremity while it is being wrapped. The room is cleaned when the service is complete.

Post-Service Clinical Labor Activities:

Phone calls are conducted with referring physician/family/caregiver.

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

CPT Long Descriptor: 29583 Application of multi-layer compression system; upper arm and forearm
(Do not report 29583 in conjunction with 29584)

Global Period: 000_____

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

APTA's Practice Expense Advisory Group consists of physical therapists who are familiar with the delivery of inpatient and outpatient physical therapy services and who have some experience with the RUC and practice expense process. In the case of services delivered by specialty/niche providers, additional physical therapists will be consulted to obtain clinical input. The Advisory Group met by phone on two occasions to develop and refine the practice expense inputs for the multi-layer compression system family of codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

The patient is met and gowned for the procedure; vital signs and other measurements (eg, circumferential measurements) are obtained and consent is obtained. The room is prepared for the patient and the patient is positioned for the procedure. A physical therapist assistant assists the therapist during the service, helping with the patient's extremity while it is being wrapped. The room is cleaned when the service is complete.

Post-Service Clinical Labor Activities:

Phone calls are conducted with referring physician/family/caregiver.

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

CPT Long Descriptor: 29584 Application of multi-layer compression system; upper arm, forearm, hand, and fingers (Do not report 29584 in conjunction with 29583)

Global Period: _000_____

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

APTA's Practice Expense Advisory Group consists of physical therapists who are familiar with the delivery of inpatient and outpatient physical therapy services and who have some experience with the RUC and practice expense process. In the case of services delivered by specialty/niche providers, additional physical therapists will be consulted to obtain clinical input. The Advisory Group met by phone on two occasions to develop and refine the practice expense inputs for the multi-layer compression system family of codes.

Please describe in detail the clinical activities of your staff:

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

The patient is met and gowned for the procedure; vital signs and other measurements (eg circumferential measurements) are obtained and consent is obtained. The room is prepared for the patient and the patient is positioned for the procedure. A physical therapist assistant assists the therapist during the service, helping with the patient's extremity while it is being wrapped. The room is cleaned when the service is complete.

Post-Service Clinical Labor Activities:

Phone calls are conducted with referring physician/family/caregiver.

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation			29582		29583		29584	
2	Meeting Date: September/October 2010	CMS	Staff	Application of a multi-layer compression system; thigh and leg		Application of a multi-layer compression system; upper arm and forearm		Application of a multi-layer compression system; arm incl hand	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD								
5	TOTAL CLINICAL LABOR TIME			21.0	0.0	20.0	0.0	21.0	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			20.0	0.0	19.0	0.0	20.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			1.0	0.0	1.0	0.0	1.0	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	Greet patient, provide gowning, ensure appropriate medical records are available	L023A	Aide	3		3		3	
21	Obtain vital signs	L039B	PTA	3		3		3	
22	Provide pre-service education/obtain consent	L039B	PTA	3		3		3	
23	Prepare room, equipment, supplies	L023A	Aide	2		2		2	
24	Setup scope (non facility setting only)								
25	Prepare and position patient/ monitor patient/ set up IV	L039B	PTA	2		2		2	
26	Sedate/apply anesthesia								
27	Intra-service								
28	Physical Therapist performing procedure	L039B	PTA	3		2		3	
29	Post-Service								
30	Monitor pt. following service/check tubes, monitors, drains								
31	Clean room/equipment by physician staff	L023A	Aide	3		3		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	L039B	PTA	1		1		1	
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	L039B	PTA	1		1		1	
43	Office visits:								
44	List Number and Level of Office Visits								
45	99211 16 minutes								
46	99212 27 minutes								
47	99213 36 minutes								
48	99214 53 minutes								
49	99215 63 minutes								
50	99238 12 minutes								
51	Total Office Visit Time			0	0	0	0	0	0
52	Other Activity (please specify)								
53	End: with last office visit before end of global period								
54	MEDICAL SUPPLIES								
55	multi specialty pack, min	SA048		1		1		1	
56	Lotion, antibacterial	SM020		1		1		1	
57	Multi-layer compression system bandages	SG096		2		1		2	
58									
59	Equipment								
60	Mat table	EF028							

	A	B	C	D	E	F	G	H	I
1	AMA/Specialty Society RVS Update Committee Recommendation			29582		29583		29584	
2	Meeting Date: September/October 2010	CMS	Staff	Application of a multi-layer compression system; thigh and leg		Application of a multi-layer compression system; upper arm and forearm		Application of a multi-layer compression system; arm incl hand	
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD								
5	TOTAL CLINICAL LABOR TIME			21.0	0.0	20.0	0.0	21.0	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			20.0	0.0	19.0	0.0	20.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			1.0	0.0	1.0	0.0	1.0	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	Greet patient, provide gowning, ensure appropriate medical records are available	L023A	Aide	3		3		3	
21	Obtain vital signs	L039B	PTA	3		3		3	
22	Provide pre-service education/obtain consent	L039B	PTA	3		3		3	
23	Prepare room, equipment, supplies	L023A	Aide	2		2		2	
24	Setup scope (non facility setting only)								
25	Prepare and position patient/ monitor patient/ set up IV	L039B	PTA	2		2		2	
26	Sedate/apply anesthesia								
27	Intra-service								
28	Physical Therapist performing procedure	L039B	PTA	3		2		3	
29	Post-Service								
30	Monitor pt. following service/check tubes, monitors, drains								
31	Clean room/equipment by physician staff	L023A	Aide	3		3		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	L039B	PTA	1		1		1	
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	L039B	PTA	1		1		1	
43	Office visits:								
44	List Number and Level of Office Visits								
45	99211 16 minutes								
46	99212 27 minutes								
47	99213 36 minutes								
48	99214 53 minutes								
49	99215 63 minutes								
50	99238 12 minutes								
51	Total Office Visit Time			0	0	0	0	0	0
52	Other Activity (please specify)								
53	End: with last office visit before end of global period								
54	MEDICAL SUPPLIES								
55	multi specialty pack, min	SA 020		1		1		1	
56	Lotion, antibacterial	SA 048		1		1		1	
57	Multi-layer compression systems	See Invoice		2		1		2	
58									
59	Equipment								
60	Mat table	EF028							

Health Care Professionals Advisory Committee (HCPAC) Summary of Recommendations
Identified as part of the CMS Fastest Growing Screen

April 2011

Otoacoustic Emissions Measurement

In October 2008, CMS identified code 92587 as part of the CMS Fastest Growing screen. In February 2010, the specialty society surveyed this service, however, after reviewing the survey data, agreed that more than one service is being represented under this code and requested the service be referred back to the CPT Editorial Panel for further clarification. The HCPAC referred code 92587 to the CPT Editorial Panel to clearly describe the services being performed.

The specialty society indicated that the explanation for the increased utilization in Medicare eligible adults reveals two distinct clinical practice patterns. The first area is the use of the procedure for early detection of hearing loss in newborns and young children who cannot perform the tasks associated with standard audiometry. The second area is the increasingly common application to determine whether there is a cochlear site of involvement for older children and hearing impaired adults as well as an objective evaluation of cochlear function in adults who are experiencing hearing loss, tinnitus, and/or the ototoxic effects of medications or other toxins. The practice patterns and use of clinical staff are also quite different between the two broad areas (screening vs. diagnosis) of application. When used for screening, the procedure is commonly performed by a medical technician or nurse under the supervision of an audiologist or physician. In contrast, when used for diagnosis, audiologists typically perform this procedure personally in the clinical or office setting as part of a multi-test diagnostic evaluation of auditory status. Therefore, in February 2011, the CPT Editorial Panel created one new code to describe the screening and revised two codes to clarify the otoacoustic emissions evaluations.

92558 Evoked otoacoustic emissions; screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis

The HCPAC reviewed the survey results from 111 audiologists and compared 92558 to the key reference code 92567 *Tympanometry (impedance testing)* (work RVU = 0.20). The survey respondents indicated, and the HCPAC agreed, that the surveyed code requires less intensity and complexity to perform than the key reference code. The HCPAC compared 92558 to other similar services such as 93000 *Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report* (work RVU = 0.17 and 5 minutes intra-service time and 2 minutes immediate post-service time), 90471 *Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)* (work RVU = 0.17 and 7 minutes intra-service time) and 11719 *Trimming of nondystrophic nails, any number* (work RVU = 0.17 and 2 minutes pre-service, 2 minutes intra-service and 5 minutes immediate post-service time). The HCPAC noted that this service is automated, but unlike 76977 *Ultrasound bone density measurement and interpretation, peripheral site(s), any method* (work RVU = 0.05) and 95905 *Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report* (work RVU = 0.05), code 92558 requires continual placement of

the probe and the application of the test for a baby by a qualified health care professional. **The HCPAC recommends 5 minutes intra-service time and 2 minutes immediate post-service time and a work RVU of 0.17 for CPT code 92558.**

92587 Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report

The HCPAC reviewed the survey results from 186 audiologists and determined that 92587 is less intense and complex, as seen in the intensity/complexity measures, compared to key reference code 92570 *Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing* (work RUC = 0.55 and 3 minutes pre-service, 15 minutes intra-service and 3 minutes immediate post-service time). The HCPAC agreed that 3 minutes pre-service, 12 minutes intra-service and 3 minutes immediate post-service time appropriately accounts for the time required to perform this evaluation. The audiologist is not only constantly monitoring the positioning of the patient and placement of the probe, but is making clinical observations of the patient throughout the test to identify any false positives from the automated examination. The HCPAC determined that the work required to perform 92587 falls between the survey 25th percentile and median, 0.35 and 0.55, respectively. The HCPAC determined that 0.45 work RVUs appropriately accounts for the work required to perform this service and therefore be directly crosswalked to 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). The HCPAC indicated that the recommended work RVU of 0.45 appropriately places this service relative to other similar services, 92250 *Fundus photography with interpretation and report* (work RVU = 0.35) and key reference service 92570 (work RVU = 0.55). **The HCPAC recommends a work RVU of 0.45 for CPT code 92587.**

92588 Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report

The HCPAC reviewed the survey results of 96 audiologists and compared 92588 to key reference service 92570 *Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing* (work RUC = 0.55 and 3 minutes pre-service, 15 minutes intra-service and 3 minutes immediate post-service time). The survey respondents indicated, and the HCPAC agreed that 92588 is more intense and complex to perform than the reference service code 92570. The HCPAC agreed that 3 minutes pre-service, 16.5 minutes intra-service and 3 minutes immediate post-service time appropriately accounts for the time required to perform this evaluation. The HCPAC determined that 92558 and 92557 *Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)* (work RVU = 0.60) require the same work and be directly crosswalked, which was supported by the survey median of 0.62. **The HCPAC recommends a work RVU of 0.60 for CPT code 92588.**

Practice Expense

The Practice Expense Subcommittee reviewed and the HCPAC agreed with the medical supplies and equipment inputs as recommended by the specialty society. The HCPAC noted that there are no clinical labor inputs as all the professional work is now captured in the work component and not in the practice expense component.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
●92558	DD1	Evoked otoacoustic emissions; screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis	XXX	0.17
▲92587	DD2	<u>Distortion product evoked otoacoustic emissions; limited evaluation (single stimulus level, either transient or distortion products to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report</u>	XXX	0.45
▲92588	DD3	comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies <u>quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies</u>), with interpretation and report (For central auditory function evaluation, see 92620, 92621)	XXX	0.60

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

CPT Code: 92558 Tracking Number DD1

Original Specialty Recommended RVU: **0.25**Presented Recommended RVU: **0.25**

Global Period: XXX

RUC Recommended RVU: **0.17**

CPT Descriptor: Evoked otoacoustic emissions; screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2-week-old girl is being seen by her pediatrician because she did not pass a previous hearing screening at birth.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 1%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The qualified healthcare professional prepares the equipment and prepares it to perform an automated otoacoustic emission screening protocol, which automatically performs the test and records the responses.

Description of Intra-Service Work: A qualified healthcare professional performs an otoscopic examination of each ear. An appropriately sized probe tip is selected and placed securely into each ear canal. An automated otoacoustic emission (OAE) screening protocol is initiated to stimulate the test and record the responses. The emissions are evaluated by the device in accordance with an automated algorithm. The qualified healthcare professional monitors the responses in accordance with automated algorithms. The algorithm determines the emissions to be present or not, yielding a result of pass or refer.

Description of Post-Service Work: After the test has been completed for each ear and the results are printed, the qualified healthcare professional reviews the results in light of any risk factors for hearing loss, completes the appropriate documentation in the child's medical chart, and informs the family of the test outcome.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Robert Fifer, PhD, Paul Pessis, AuD				
Specialty(s):	Audiology				
CPT Code:	92558				
Sample Size:	368	Resp N:	111	Response: 30.1 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	10.00	50.00	112.00
Survey RVW:		0.15	0.25	0.30	0.40
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	5.00	10.00	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 0.00	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:	92558	Recommended Physician Work RVU: 0.17		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92567	XXX	0.20	RUC Time

CPT Descriptor Tympanometry (impedance testing)**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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
11719	000	0.17	RUC Time	1,472,007

CPT Descriptor 1 Trimming of nondystrophic nails, any number

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
95831	XXX	0.30	Other	47,303

CPT Descriptor 2 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
		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: 59 % of respondents: 53.1 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 92558	<u>Key Reference CPT Code:</u> <u>92567</u>	<u>Source of Time</u> RUC Time
Median Pre-Service Time	0.00	1.00	
Median Intra-Service Time	5.00	4.00	
Median Immediate Post-service Time	2.00	1.00	
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	7.00	6.00	

Other time if appropriate		
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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	2.42	2.59
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	2.42	2.36
--	------	------

Urgency of medical decision making	3.03	2.76
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	2.36	2.58
--------------------------	------	------

Physical effort required	1.83	1.88
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.71	1.54
---	------	------

Outcome depends on the skill and judgment of physician	2.36	2.54
--	------	------

Estimated risk of malpractice suit with poor outcome	2.14	1.76
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	1.95	1.90
----------------------------------	------	------

Intra-Service intensity/complexity	2.61	2.34
------------------------------------	------	------

Post-Service intensity/complexity	2.24	2.19
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Additional Rationale and Comments

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

Specialty pediatrics Frequency 13000 Percentage 22.74 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is a procedure used with infants .

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

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. 92567

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

CPT Code: 92587 Tracking Number DD2

Original Specialty Recommended RVU: **0.55**Presented Recommended RVU: **0.55**

Global Period: XXX

RUC Recommended RVU: **0.45**

CPT Descriptor: Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A two-year-old boy is referred by his pediatrician for objective estimation of hearing sensitivity due to delays in speech and language development. Recent attempts to obtain behavioral hearing evaluation results yielded inconclusive information. Supplemental testing is needed to obtain additional information regarding hearing function.

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 5%

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? 2%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

The audiologist performs a chart review. The audiologist accesses the otoacoustic software and the appropriate frequency and signal averaging protocol. The patient's demographic information and medical record number are entered into the testing software and the otoacoustic emission (OAE) screening interface is activated.

Description of Intra-Service Work:

The audiologist briefly affirms key elements of the history and presenting concerns, explains the purpose of the procedure to the patient's parents or guardian. The audiologist then informs the parent or guardian of what to expect when the test is under way and instructs the parent on the proper positioning of the child throughout the procedure. The audiologist performs an otoscopic examination of each ear, an appropriate-sized probe tip is selected, and the stimulus/recording probe assembly is inserted into the patient's ear canal. Once properly seated, the protocol is activated. Under the constant observation of the audiologist, the testing software performs a calibration to ensure proper probe placement and the absence of blockage. The test protocol continues with the evaluation of the first test frequency. Tonal pairs are presented to the patient's ear; after each presentation the OAE equipment waits approximately 2 to 6 milliseconds to record evidence of sensory cell movement in the cochlea. The process is repeated for approximately 500 samples in order to perform a signal-averaging algorithm to separate the anticipated otoacoustic emission from the noise floor from either the patient or the environment. Once the requisite number of samples is collected for the first frequency pair, the OAE equipment changes frequency pairs according to the selected protocol and repeats the procedure. This algorithm is repeated until data for three

to six frequency pairs are collected. Results are then displayed on the OAE equipment screen by frequency for the otoacoustic emission amplitude and the level of the noise floor in decibels. When the first ear is completed, the process is repeated for the second ear. The audiologist evaluates the data to determine whether a biologic (in contrast to artifactual) response was obtained at each frequency. Results are printed for placement in the patient's medical chart. The audiologist prepares a report describing the measurements, outcomes, and recommendations.

Description of Post-Service Work: Post-service work includes describing the results to the patient's family and notifying the referring physician of the test outcomes.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Robert C. Fifer, PhD; Paul Pessis, AuD				
Specialty(s):	Audiology				
CPT Code:	92587				
Sample Size:	496	Resp N:	186	Response: 37.5 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	62.50	150.00	340.50
Survey RVW:		0.20	0.35	0.55	0.60
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	10.00	12.00	15.00
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:	92587	Recommended Physician Work RVU: 0.45		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		12.00		
Immediate Post Service-Time:		3.00		
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92570	XXX	0.55	RUC Time

CPT Descriptor Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99201	XXX	0.48	RUC Time	321,183

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires 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.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97002	XXX	0.60	RUC Time	401,968

CPT Descriptor 2 Physical therapy re-evaluation

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
93285	XXX	0.52	RUC Time

CPT Descriptor Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 71 **% of respondents:** 38.1 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 92587	<u>Key Reference CPT Code:</u> 92570	<u>Source of Time RUC Time</u>
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	12.00	15.00	
Median Immediate Post-service Time	3.00	3.00	
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	18.00	21.00
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	3.63	3.49
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.49	3.25
Urgency of medical decision making	3.37	3.14

Technical Skill/Physical Effort (Mean)

Technical skill required	3.61	3.46
Physical effort required	2.61	2.56

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.96	1.92
Outcome depends on the skill and judgment of physician	3.51	3.38
Estimated risk of malpractice suit with poor outcome	2.65	2.38

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	2.41	2.15
Intra-Service intensity/complexity	3.56	3.42
Post-Service intensity/complexity	3.14	2.83

Additional Rationale and Comments

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

We convened an expert panel to review the survey data, obtained from audiologists who volunteered to participate, and develop recommendations for an RVW, PE inputs and pre, intra and post time. We are recommending acceptance of the median intra time of 12 minutes but would reduce the pre and post time to 3 minutes each.

The RVW recommended is identical to the RVW assigned to the key reference code 92570. While the intra time of the reference code is slightly higher (15 compared with 12 minutes), the intensity and complexity measures are consistently higher for the surveyed code. The RVW is further supported by the values assigned to the key MPC codes cited which bracket the recommended RVW. Code 99201, which is a Level 1 office or outpatient visit for a new patient, is assigned an RVW of 0.48 for 10 minutes of intra time and Code 97002 Physical therapy re-evaluation, is assigned an RVW of 0.60 for 18 minutes of intra time.

Finally, we are citing an additional code, 93285 (Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system) which lends further credence to the recommended RVW. This code is assigned an RVW of 0.52 for the same intra time as the surveyed code.

The expert panel noted that some respondents indicated that moderate sedation is used for this procedure. Our expert panel reports that children are never sedated for the sole purpose of performing otoacoustic emissions. If a child is under sedation for another purpose, the audiologist may perform otoacoustic emissions by prior arrangement.

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) 92587

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 audiology

How often? Commonly

Specialty otorhinolaryngology How often? Commonly

Specialty internal medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 200000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty audiology	Frequency 54000	Percentage 27.00 %
Specialty otorhinolaryngology	Frequency 72000	Percentage 36.00 %
Specialty internal medicine	Frequency 46000	Percentage 23.00 %

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

57,700 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

Specialty audiology	Frequency 15579	Percentage 27.00 %
Specialty otorhinolaryngology	Frequency 20772	Percentage 36.00 %
Specialty internal medicine	Frequency 13271	Percentage 23.00 %

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 92587

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: 92588 Tracking Number DD3

Original Specialty Recommended RVU: **0.81**Presented Recommended RVU: **0.81**

Global Period: XXX

RUC Recommended RVU: **0.60**

CPT Descriptor: Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report

(for central auditory function evaluation, see 92620, 92621)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 56-year old woman with a diagnosis of cancer is referred by her oncologist for a baseline assessment of cochlear hair cell function prior to the initiation of a potentially ototoxic regimen of chemotherapy.

Percentage of Survey Respondents who found Vignette to be Typical: 71%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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? 4%

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? 2%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work: The audiologist performs a chart review. The audiologist selects a specific test protocol for number of octaves to be assessed and the number of frequencies to be evaluated for each octave.

Description of Intra-Service Work: The audiologist performs an otoscopic examination of each ear. Once the appropriate-sized probe tip is selected and placed on the acoustic probe assembly, it is inserted directly into each ear canal. During the test administration the audiologist continually assesses the collected data to determine if changes to the test protocol are warranted. The measurement of distortion product otoacoustic emissions is repeated for multiple frequencies per octave across multiple octaves. The responses are then replicated to establish validity and reliability of the distortion products. The amplitudes of the distortion product otoacoustic emissions relative to the noise floor are evaluated for distinct response patterns signifying frequency regions of good cochlear function, frequency regions where function is compromised but not eliminated, and frequency regions where there is no residual function. The audiologist performs a detailed analysis of the graphic display of these collective responses which constitutes a frequency map of the cochlea consistent with the status of the cochlear outer hair cells. After the protocol has been completed on the first ear, the procedure is repeated for the second ear. When the test protocol has been completed for both ears, the audiologist interprets the test results by comparing the response amplitudes to normative data and/or previous test results. The audiologist then prepares a report for the referring physician.

Description of Post-Service Work: The audiologist reviews the results with the patient. The results are printed and the audiologist finalizes the documentation for entry into the medical chart. The audiologist then sends a report to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Robert C. Fifer, PhD, Paul Pessis, AuD				
Specialty(s):	Audiology				
CPT Code:	92588				
Sample Size:	332	Resp N:	96	Response: 28.9 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	20.00	50.00	102.50
Survey RVW:		0.27	0.55	0.62	0.81
Pre-Service Evaluation Time:				5.00	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		0.35	11.50	16.50	25.00
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:	92588	Recommended Physician Work RVU: 0.60		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		16.50		
Immediate Post Service-Time:		3.00		
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92570	XXX	0.55	RUC Time

CPT Descriptor Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97755	000	0.62	RUC Time	2,397

CPT Descriptor 1 Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
97001	XXX	1.20	RUC Time	1,837,218

CPT Descriptor 2 Physical therapy evaluation

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
21116	XXX	0.81	RUC Time

CPT Descriptor Injection procedure for temporomandibular joint arthrography

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 32 % of respondents: 33.3 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 92588	<u>Key Reference CPT Code:</u> 92570	<u>Source of Time</u> RUC Time
Median Pre-Service Time	3.00	3.00	
Median Intra-Service Time	16.50	15.00	
Median Immediate Post-service Time	3.00	3.00	
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	22.50	21.00
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	3.78	3.41
--	------	------

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.72	3.22
--	------	------

Urgency of medical decision making	3.53	2.94
------------------------------------	------	------

Technical Skill/Physical Effort (Mean)

Technical skill required	3.63	3.31
--------------------------	------	------

Physical effort required	2.25	2.16
--------------------------	------	------

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	2.13	1.94
---	------	------

Outcome depends on the skill and judgment of physician	3.75	3.34
--	------	------

Estimated risk of malpractice suit with poor outcome	2.53	2.25
--	------	------

INTENSITY/COMPLEXITY MEASURES **CPT Code** **Reference Service 1**

Time Segments (Mean)

Pre-Service intensity/complexity	2.56	2.41
----------------------------------	------	------

Intra-Service intensity/complexity	3.56	3.19
------------------------------------	------	------

Post-Service intensity/complexity	3.34	3.00
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Additional Rationale and Comments

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

We convened an expert panel to review the survey data, obtained from audiologists who volunteered to participate, and develop recommendations for an RVW, PE inputs and pre, intra and post time.

We recognize that recommending an RVW above the median value is somewhat unusual and we want to fully explain the rationale for this decision. In our judgment, the main problem is that a number of the survey respondents did not fully appreciate the change in the language to this code compared to Code 92587. The language of 92587 and 92588 was changed because of long-standing confusion as to the distinction between these codes. The original descriptors attempted to take into account two different types of technologies for measuring otoacoustic emissions (transient and distortion product otoacoustic emissions) in each code. The original (current) limited code (92587) descriptor described the procedure in the following manner:

Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products).

The diagnostic otoacoustic emissions procedure (92588) currently is defined as follows:

Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies).

When the codes were developed in 1994, transient otoacoustic emissions were the predominant form of testing. Distortion product instruments were just becoming available. Since that time, the use of transient otoacoustic emissions instruments has diminished such that only a very small percentage of audiologists now use that technique. Overwhelmingly, research has emphasized the clinical utility of distortion product otoacoustic measurements. The point is that one of the main tenets of 92588, according to the descriptor, could no longer be met: the comparison of the two measurement techniques. For the majority of audiologists, only distortion product devices are used for which there was no guidance on the number of frequencies necessary to meet requirements for a diagnostic procedure. In the past, many audiologists believed that use of only six frequencies could constitute a diagnostic procedure versus four frequencies for a limited. This was one of the reasons that we made the descriptors for 92587 versus 92588 clearly distinguished based on number of frequencies tested. There is clearly increased professional work as the number of frequencies increase.

With this background, we note that the raw survey data showed confusion between 92587 and 92588 in the minds of a significant number of individuals completing the survey. A review of the raw data revealed that 49 respondents valued 92588 exactly the same as 92587 relative to intra-service times and recommended RVWs. Moreover, the same CPT code, 92570, was the primary reference for 92588 as for 92587. Lastly, the median time for 92588 is 16.50 minutes, not substantially different than the median time for 92587 of 12 minutes. It is noteworthy that the maximum number of frequencies for 92587 is 6 while the minimum number for 92588 is 12. Given that it takes the same amount of time per frequency to collect the data, the intra-service time for 92588 should be substantially longer than for 92587. The 75th percentile median intra-service time for 92588 confirms the premise that the time for the procedure will increase substantially when the number of frequencies increase since it shows 25 minutes compared to 12 minutes for 92587. These arguments support the recommendation of the 75th percentile for intra-service time and RVW for 92588, especially when considering that the interpretation and report are included in the inter-service time in accordance with the survey instrument.

In further support of our recommended RVW, we are citing 2 MPC codes whose RVW's bracket the recommended value. Code 97755 (Assistive technology assessment) with an RVW of 0.62 and 15 minutes of intra time and Code 97001 (Physical therapy evaluation), with an RVW of 1.20 and 30 minutes of intra time. An additional comparison code that supports the recommendation includes: 21116 (Injection procedure for temporomandibular joint arthrography; RVW=0.81 with 25 minutes of intra time).

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 code may be reported with 92552 (Pure tone audiometry (threshold); air only) in order to document hearing sensitivity in addition to the status of sensory cell structure in the cochlea.

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 may be reported with 92552 (Pure tone audiometry (threshold); air only) in order to document hearing sensitivity in addition to the status of sensory cell structure in the cochlea. CPT 92552 does not contain physician work and has a non-facility PE RVU of 0.74 and 26 minutes of intra for clinical staff time.

CPT Code	Global Period	RVW	Pre-Service	Intra-Service	Post-Service	Total Time
92588	XXX	0.81	4	25	5	34
92552	XXX	0.00	0	0	0	0
Sum		0.81	4	25	5	34

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 92588

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 audiology How often? Commonly

Specialty otorhinolaryngology How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 125824

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty audiology Frequency 450000 Percentage 70.09 %

Specialty otorhinolaryngology Frequency 190000 Percentage 29.59 %

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?
125,824 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 for 2009 Medicare Claims

Specialty audiology Frequency 88000 Percentage 69.93 %

Specialty otorhinolaryngology Frequency 37500 Percentage 29.80 %

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 92588

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.

	A	B	C	D	E	F	G	H	I
1				92558		92587		92588	
	Meeting Date: 04/2011 AMA/Specialty Society RVS Update Committee Recommendation			Evoked otoacoustic emissions; screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis		Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report		Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report (for central auditory function evaluation, see 92620, 92621)	
2		CMS	Staff						
3	LOCATION	Code	Type	Facility	Facility	Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD								
5	TOTAL CLINICAL LABOR TIME			0.0	0.0	0.0	0.0	0.0	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			0.0	0.0	0.0	0.0	0.0	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	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								
51	<i>Total Office Visit Time</i>			0	0	0	0	0	0
52	Other Activity (please specify)								
53	End: with last office visit before end of global period				0		0		0
54	MEDICAL SUPPLIES		Unit						
55	ear tip, immittance	SD045		1		1		1	
56	specula tips, otoscope	SM025				1		1	
57	'paper, recording (per sheet)	SK059		2		2		2	
58	swab-pad, alcohol	SJ053		2		2		2	
59	Equipment		Min						
60	'audiometric soundproof booth (exam and control rooms)	EQ054		5		12		25	
61	'OAE-otoacoustic emission system	EQ034		5		12		25	
62	chair with headrest, exam, reclining	EF008		5		12		25	

Health Care Professionals Advisory Committee (HCPAC) Summary of Recommendations
Identified as part of the CMS Request/Speech Language Pathology Request

April 2011

Evaluation for Prescription of Non-Speech Generating-Augmentive and Alternative Communication Device

On July 15, 2008, H.R. 6331 Medicare Improvements for Patients and Providers Act of 2008 was signed into law. Section 143 of HR 6331 specifies that speech-language pathologists may independently report services they provide to Medicare patients. Starting in July 2009, speech-language pathologists were able to bill Medicare independently as private practitioners.

On October 9, 2008, the American Speech-Language-Hearing Association (ASHA) requested that CMS, in light of the recent legislation, base speech-language pathology services on professional work values and not through the practice expense component. CMS requested that the RUC review the speech-language pathology codes for professional work as requested by ASHA.

In February 2010, after reviewing the survey data for this service the specialty society indicated and the HCPAC agreed that code 92605 would be better captured as a “per hour” code. The HCPAC recommended that this service be referred back to the CPT Editorial Panel for modification. In February 2011, the CPT Editorial Panel revised 92605 to indicate “first hour” and created a new add-on code to capture each additional 30 minutes.

92605 Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour

The HCPAC reviewed the survey results from 42 speech language pathologists and compared 92605 to the key reference service 92607 *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour* (work RVU = 1.85). Although the survey respondents recommended the same time as the key reference code, the HCPAC agreed that the intensity and complexity for the surveyed code is slightly lower than the key reference code. The qualified health care professional is evaluating the patient by interacting with the patient and caregiver to appropriately interpret feedback/communication from the patient. Given this comparison, the HCPAC determined that the survey median work RVU of 1.75 and pre-time of 10 minutes, intra-time of 60 minutes and 20 minutes of immediate post-service work appropriately account for the work and time required to perform this evaluation. **The HCPAC recommends a work RVU of 1.75 for CPT code 92605.**

92618 Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)

The HCPAC reviewed the survey results from 32 speech language pathologists and compared the work of 92618 to the key reference service 92608 *Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU = 0.70). The HCPAC

determined that the intensity and complexity for the surveyed code is slightly lower than the key reference code and agreed that survey 25th percentile work RVU of 0.65 and 30 minutes of intra-service work appropriately accounts for the work and time required to perform these additional minutes of evaluation. The qualified health care professional is evaluating the patient by interacting with patient and caregiver to appropriately interpret feedback/communication from the patient. **The HCPAC recommends a work RVU of 0.65 for CPT code 92618.**

Practice Expense

The Practice Expense Subcommittee reviewed and the HCPAC agreed with the medical supplies and equipment inputs as recommended by the specialty society. The HCPAC noted that there are no clinical labor inputs as all the professional work is now captured in the work component and not in the practice expense component.

CPT Code (●New)	Track- ing Num- ber	CPT Descriptor	Global Period	Work RVU Recommendation
▲92605	EE1	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, <u>face-to-face with the patient; first hour</u>	XXX	1.75
● +92618	EE2	each additional 30 minutes (List separately in addition to code for primary procedure)	ZZZ	0.65

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

CPT Code: 92605 Tracking Number EE1

Original Specialty Recommended RVU: **1.75**Presented Recommended RVU: **1.75**

Global Period: XXX

RUC Recommended RVU: **1.75**

CPT Descriptor: Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4-year old male with cerebral palsy, severely unintelligible speech, and severe motoric impairment is referred for a non-speech-generating augmentative and alternative communication device evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 54%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

- Review intake materials (medical/educational records & case history form)
- Review questionnaire completed by family/caregivers to clarify and expand on information on questionnaire;
- Consult with other team members (e.g., pediatrician/occupational therapy/physical therapy/speech-language pathology/vision/social work/educational team members/nursing) regarding needs/initial vocabulary;
- Organize and set up materials (e.g., create or develop initial communication boards for trial typically using specialized software programs).

Description of Intra-Service Work:

- Conduct observations, interactions, and evaluations to gather information about functional vision, hearing, motor, cognition, communication, and language skills that will be utilized in a communication system;
- Determine optimal access method, level of symbolic representation, symbol size, display layout, vocabulary, message formulation methods and accessories needed to carry or mount communication displays/boards;
- Identify techniques that will maximize effective communication between the patient and his/her communication partners;
- Interact with patient and caregiver to appropriately interpret feedback/communication for the patient and counsel caregiver throughout evaluation including discussion of recommendations.

Description of Post-Service Work:

- Research additional information required to complete report (e.g., specific mounting requirements, materials to construct boards, symbols set availability);
- Document results of the evaluation and individualized recommendations for creation and implementation of a communication system, which includes specific equipment and communication techniques
- Follow up and coordinate with family and caregivers regarding recommendations and any additional needs that arise (assist with initial vocabulary determination).

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011				
Presenter(s):		Dee Adams Nikjeh, PhD, CCC-SLP, Kathlee Post, MS, CCC-SLP				
Specialty(s):		Speech-Language Pathology				
CPT Code:		92605				
Sample Size:	106	Resp N:	42	Response: 39.6 %		
Sample Type: Panel		Additional Sample Information:				
		Low	25th pctl	Median*	75th pctl	High
Service Performance Rate		0.00	3.00	5.00	12.75	120.00
Survey RVW:		1.20	1.75	1.83	2.00	12.34
Pre-Service Evaluation Time:				45.00		
Pre-Service Positioning Time:				0.00		
Pre-Service Scrub, Dress, Wait Time:				0.00		
Intra-Service Time:		50.00	60.00	90.00	120.00	240.00
Immediate Post Service-Time:		60.00				
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:	92605	Recommended Physician Work RVU: 1.75		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		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 0.0	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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92607	XXX	1.85	RUC Time

CPT Descriptor Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour

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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99214	XXX	1.50	RUC Time	72,747,651

CPT Descriptor 1 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 detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
90801	XXX	2.80	RUC Time	1,405,376

CPT Descriptor 2 Psychiatric diagnostic interview examination

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
90806	XXX	1.86	RUC Time

CPT Descriptor 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;

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

Compare the pre-, intra-, and post-service time (by the median) and the 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: 39 **% of respondents:** 92.8 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 92605	<u>Key Reference CPT Code:</u> 92607	<u>Source of Time RUC Time</u>
Median Pre-Service Time	10.00	10.00	
Median Intra-Service Time	60.00	60.00	
Median Immediate Post-service Time	20.00	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	90.00	90.00
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	4.28	4.59
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4.15	4.26
Urgency of medical decision making	3.62	3.95

Technical Skill/Physical Effort (Mean)

Technical skill required	4.26	4.79
Physical effort required	3.49	3.67

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.77	2.03
Outcome depends on the skill and judgment of physician	4.31	4.51
Estimated risk of malpractice suit with poor outcome	1.92	2.13

INTENSITY/COMPLEXITY MEASURES**CPT Code****Reference Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.38	3.67
Intra-Service intensity/complexity	4.33	4.72
Post-Service intensity/complexity	3.95	4.36

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 92605 is for the evaluation for prescription of a non-speech generating code. We are recommending an RVW of 1.75 based on the 25th percentile of the survey data. While this code is a “per hour” code, the median intra time reported was 90 minutes. The median RVW reported was 1.83. We are recommending an intra time of 60 minutes which represents the 25th percentile of intra time and is consistent with the per hour code definition.

We are recommending pre time of 10 minutes and post time of 20 minutes which is substantially less than both the median and the 25th percentile of pre and post time. The pre and post time being recommended are consistent with the times approved by the RUC and CMS for a very similar per hour code, Code 92607 Evaluation for Speech-Generating Device, which served as the most frequently selected reference code for the surveyed code.

Evaluating a severely handicapped patient, usually a young child, for a non-speech generating augmentative and alternative communication device is a very time consuming procedure and we anticipate that Code 92605 will be typically reported with one or two units of the add-on Code 92618. As an add-on code with a ZZZ global status, Code 92618 is not assigned any pre and post time. All pre- and post-time is assigned to the base code.

As noted, we are recommending an RVW of 1.75 based on the 25th percentile of the survey date. Assigning a slightly lower value to this code compared to the reference code of 92607 seems appropriate since the weights assigned to the complexity measures for the surveyed code are slightly lower than for the reference code. Since these are both per hour codes, a slightly lower RVW seems justified which is why we are recommending an RVW of 1.75 compared with the RVW of 1.86 for the reference code.

In further support, we are citing two MPC codes for comparison purposes which we think appropriately bracket our requested RVW of 1.75. At the high end, Code 90801 is a psychiatric diagnostic interview examination which is assigned an RVW of 2.80 This is also a code involving 60 minutes of intra time and is assigned an IWPUT of 0.0224. The second MPC code, 99214, is a level 4 office visit for an established patient. It is assigned an RVW of 1.50 for 25 minutes of intra time. The IWPUT for Code 90801 is 0.0224 while the IWPUT for Code 99214 is 0.0466. In comparison, using the recommended times and RVW, the IWPUT for the surveyed code would be 0.0180 considerably less than these two MPC codes.

Finally, in support of the recommended RVW we would cite code 90806 which is defined as Individual psychotherapy, insight oriented, behavior modifying or supportive, involving 45-50 minutes of face to face time. It is assigned an RVW of 1.86, 50 minutes of intra time which is reported most often by clinical social workers. This code has an IWPUT of 0.0372 or twice that of the surveyed code using recommended times and work values.

CPT Code	RVW	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
99214 Office or other outpatient visit for the evaluation and management of an established patient (Level 4)	1.50	5	25	10	40	0.0466
92605 Non SGD evaluation prescription	1.75	10	60	20	90	0.0180
90806 Individual psychotherapy,	1.86	0	50	0	50	0.0372
90801 Psychiatric diagnostic interview examination	2.80	10	60	55	125	0.0224

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.)

Specialty	Frequency	Percentage	%
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Specialty	Frequency	Percentage	%
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Do many physicians perform this service across the United States? No

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 92605

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:92618 Tracking Number EE2

Original Specialty Recommended RVU: **0.65**Presented Recommended RVU: **0.65**

Global Period: ZZZ

RUC Recommended RVU: **0.65**

CPT Descriptor: Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4-year old male with cerebral palsy, severely unintelligible speech, and severe motoric impairment is referred for a non-speech-generating augmentative and alternative communication device evaluation.

Percentage of Survey Respondents who found Vignette to be Typical: 59%

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% , Kept overnight (less than 24 hours) 0% , Admitted (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%

Is moderate sedation inherent in your reference code (Office setting)? No

Is moderate sedation inherent in your reference code (Hospital/ASC setting)? No

Description of Pre-Service Work:

Description of Intra-Service Work:

- Conduct observations, interactions, and evaluations to gather information about functional vision, hearing, motor, cognition, communication, and language skills that will be utilized in a communication system;
- Determine optimal access method, level of symbolic representation, symbol size, display layout, vocabulary, message formulation methods and accessories needed to carry or mount communication displays/boards;
- Identify techniques that will maximize effective communication between the patient and his/her communication partners;
- Interact with patient and caregiver to appropriately interpret feedback/communication for the patient and counsel caregiver throughout evaluation including discussion of recommendations.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)		04/2011			
Presenter(s):	Dee Adams Nikjeh, PhD, CCC-SLP; Kathleen Post, MS, CCC-SLP				
Specialty(s):	Speech-Language Pathology				
CPT Code:	92618				
Sample Size:	107	Resp N:	32	Response: 29.9 %	
Sample Type:	Panel	Additional Sample Information:			
		Low	25th pctl	Median*	75th pctl
Service Performance Rate		0.00	4.00	5.00	10.50
Survey RVW:		0.00	0.65	1.35	1.85
Pre-Service Evaluation Time:				32.50	
Pre-Service Positioning Time:				0.00	
Pre-Service Scrub, Dress, Wait Time:				0.00	
Intra-Service Time:		0.00	30.00	60.00	90.00
Immediate Post Service-Time:		52.50			
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:	92618	Recommended Physician Work RVU: 0.65		
		Specialty Recommended Pre-Service Time	Specialty Recommended Pre Time Package	Adjustments to 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:		30.00		
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:

<u>Key CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92608	ZZZ	0.70	RUC Time

CPT Descriptor Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient, each additional 30 minutes (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.

<u>MPC CPT Code 1</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99212	XXX	0.48	RUC Time	19,660,131

CPT Descriptor 1 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.

<u>MPC CPT Code 2</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>	<u>Most Recent Medicare Utilization</u>
99213	XXX	0.97	RUC Time	101,611,468

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

<u>Other Reference CPT Code</u>	<u>Global</u>	<u>Work RVU</u>	<u>Time Source</u>
92557	XXX	0.60	RUC Time

CPT Descriptor Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)

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

Compare the pre-, intra-, and post-service time (by the median) and the 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:** 87.5 %

TIME ESTIMATES (Median)

	<u>CPT Code:</u> 92618	<u>Key Reference CPT Code:</u> 92608	<u>Source of Time RUC Time</u>
Median Pre-Service Time	0.00	0.00	
Median Intra-Service Time	30.00	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	30.00
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	4.07	4.25
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	3.96	4.11
Urgency of medical decision making	3.14	3.46

Technical Skill/Physical Effort (Mean)

Technical skill required	4.29	4.75
Physical effort required	3.36	3.54

Psychological Stress (Mean)

The risk of significant complications, morbidity and/or mortality	1.89	2.11
Outcome depends on the skill and judgment of physician	4.18	4.43
Estimated risk of malpractice suit with poor outcome	1.96	2.29

INTENSITY/COMPLEXITY MEASURES**CPT Code** **Reference
Service 1****Time Segments (Mean)**

Pre-Service intensity/complexity	3.39	3.64
Intra-Service intensity/complexity	4.07	4.50
Post-Service intensity/complexity	3.79	4.14

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.*

We are recommending an RVW of 0.65 which is based on the 25th percentile of survey data. This is an add-on code for each additional 30 minutes which is billed in addition to the first hour code, 92605, for which we have recommended an RVW of 1.75. Intra time for Code 92618 would be 30 minutes consistent with the code definition. We would eliminate all pre and post time since this is a ZZZ add-on code.

The recommended RVW is supported in comparison to the reference code 92608 which is assigned an RVW of 0.70. Code 92608 is very similar to Code 92618 being a per 30-minute add-on code for evaluating a patient for a speech generating device. Since the intensity measures are slightly lower for the surveyed code, we think a RVW of 0.65 is appropriate.

In further support, we would cite two MPC codes which bracket the recommended RVW. Code 99212 is a level 2 office visit for an established patient. It is assigned an RVW of 0.48 and intra time of 10 minutes. Code 99213 is a mid-level office visit for an established patient. It is assigned an RVW of 0.97 for 15 minutes of intra time. The IWPUT for Code 99212 is 0.0346 and 0.0527 for Code 99213. In comparison, using the recommended RVW of 0.65 and intra time of 30 minutes, the IWPUT for Code 92618 would be 0.02167 which is less than half of the IWPUT for Code 99213.

Finally we would point to Code 92557, comprehensive audiometry testing, which is assigned an RVW of 0.60 for 20 minutes of intra time. The IWPUT for the surveyed code using the recommended times and values is virtually identical to this diagnostic procedure.

CPT Code	RVW	Pre-Service	Intra-Service	Post-Service	Total Time	IWPUT
99212 Office or other outpatient visit for the evaluation and management of an established patient (Level 2)	0.48	2	10	4	16	0.0346
92557 Comprehensive audiometry testing	0.60	3	20	5	28	0.0210
92618 Non SGD evaluation prescription; each additional 30 minutes	0.65	0	30	0	30	0.02167
99213 Office or other outpatient visit for the evaluation and management of an established patient	0.97	3	15	5	23	0.0527

SERVICES REPORTED WITH MULTIPLE CPT CODES

- 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)

- 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

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

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. 92605

	A	B	C	D	E	F	G
1	Tab 35			92605		92618	
	Meeting Date: 04/2011 AMA/Specialty Society RVS Update Committee Recommendation			Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour		Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes	
2		CMS	Staff				
3	LOCATION	Code	Type	Non Facility	Facility	Non Facility	Facility
4	GLOBAL PERIOD		L9999				
5	TOTAL CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
6	TOTAL PRE-SERV CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
7	TOTAL SERVICE PERIOD CLINICAL LABOR TIME			0.0	0.0	0.0	0.0
8	TOTAL POST-SERV CLINICAL LABOR TIME			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	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	<i>Office visits:</i>						
51	<i>Total Office Visit Time</i>			0	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	gloves, non-sterile	SB022	pair	1			
56	lamination sheet (letter size)	SK044	item	1			
57	paper, card stock (8.5 x 11)	SK055	item	10			
58	Velcro, standard	SK084	foot	3			
59	swab-pad, alcohol	SJ053	item	10			
60	tongue depressor	SJ061	item	1			
61	Equipment		Min				
62	computer, desktop, w-monitor	ED021		60		30	
63	augmentative communication - Hand Held Voice	EQ060		60		30	
64	augmentative communication - Tech Speak	EQ063		60		30	
65	'augmentative communication - VoicePal Max	EQ065		60		30	